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FINANCING OF LONG-TERM CARE

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON FINANCE

UNITED STATES SENATE

ONE HUNDREDTH CONGRESS

FIRST SESSION

JUNE 12, 1987

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FINANCING OF LONG-TERM CARE

FRIDAY, JUNE 12, 1987

U.S. SENATE,
SUBCOMMITTEE ON HEALTH,
COMMITTEE ON FINANCE,
Washington, DC.

The committee was convened, pursuant to notice, at 10:00 a.m. in room SD-215, Dirksen Senate Office Building, the Honorable George J. Mitchell (chairman) presiding.

Present: Senators Mitchell, Bradley, Riegle, Rockefeller, Chafee, and Durenberger.

[The press release announcing the hearing and the prepared statements of Senators Rockefeller and Heinz follow:]

[Press Release No. H-47, May 18, 1987]

FINANCE SUBCOMMITTEE ON HEALTH TO HOLD HEARING ON FINANCING OF LONG-TERM CARE

WASHINGTON, DC—Senator George J. Mitchell (D., Maine), Chairman, announced Friday that the Subcommittee on Health of the Senate Finance Committee will hold the third in a series of hearings on long-term care.

Chairman Mitchell stated that the focus of the hearing will be the financing of long-term care. The Subcommittee is interested in examining ways in which the private insurance industry and the public sector can work together to insure that care is available for those elderly or disabled citizens who require nursing home care or assistance in their homes. Senator Mitchell stated that the Subcommittee hopes to explore ways in which Federal policy can help create a better market for long-term care insurance, and also assure access to long-term care for those who cannot afford insurance, or whose chronic conditions lead to exhaustion of private coverage.

The hearing will be held on Friday, June 12, 1987 at 10:00 a.m. in room SD-215 of the Dirksen Senate Office Building.

STATEMENT OF SENATOR JOHN D. ROCKEFELLER IV

Thank you, Mr. Chairman. I would like to start by saying that I think we all should be grateful for your obvious deep concern about this problem of long-term care. We know your schedule is especially burdensome, with the Iran hearings taking up so much of your time. Yet, in the recent weeks, you have managed to introduce important legislation to ease the "spousal impoverishment" problem. I am pleased to be a cosponsor of that bill and to join Senator Bradley, you, and others in proposing legislation to improve Medicare's home health benefit—both of these initiatives tie in with our overall goal of protecting seniors from going without necessary medical care.

Today, I hope to learn more about a difficult, complex question. What can Congress do to make more financing available for long-term care and services? We know the current arrangements are unacceptable in many ways. Wives forced to live in poverty because their husbands have to enter nursing homes through the Medicaid program. More than half of Medicaid dollars in states going to nursing home care and draining away scarce resources from the pressing needs of poor families. Elderly at home being neglected because they have no children nearby or have no family at all to care for them—and few services available to them from government programs. An extremely limited private insurance market for long-term care. And so on.

Mr. Chairman, I just returned from holding a public forum on home health in West Virginia. I heard about far more than the problems with Medicare's home health benefit—and let me tell you, what I heard about HCFA and its attitude about home health made me madder and more determined than ever.

The seniors who attended my forum are worried and they're scared. They don't understand why our catastrophic coverage legislation doesn't take care of long-term care. Many may even assume we are addressing this problem in the catastrophic package. They see the trends themselves. They see the growing number of senior citizens in their communities and the growing need for care—at home, at senior centers, and at nursing homes. They want Congress to do something.

I am sensitive to just how great of a challenge and how difficult of a task are presented by this long-term care issue. Today, I want to get a better understanding of the dimensions of the need. I'm especially interested in the potential role the private sector can play in offering and marketing long-term care coverage. But I join you, Senator Mitchell, in actively seeking solutions. With the help of the witnesses today and many other experts, we are going to have to figure out ways to broaden government and private coverage of care that an increasing proportion of our population will desperately need.

STATEMENT BY SENATOR JOHN HEINZ

Mr. Chairman: As former Chairman and now Ranking Member of the Special Committee on Aging, I am particularly appreciative of your calling this hearing today. Congress soon will vote on a measure to limit out-of-pocket expenses for hospitals and doctors—the catastrophic acute costs. But providing for catastrophic acute-care costs still leaves American families facing the more common catastrophe of outlays for long-term, chronic illness.

For five out of six older Americans long-term care, not acute care, is the crippling expense—$8 out of every $10 of catastrophic health costs are spent outside the hospital, usually in a nursing home. Even a middle-income family's financial resources will be drained by nursing home costs that average more than $22,000 a year. Millions of Americans, particularly middle-age women, find their physical and emotional resources stretched to their limits when they assume the task of caring for an aged parent. The bill that we passed out of Committee a few weeks ago does nothing to address these problems.

What we lack and what we need is a comprehensive solution to the crisis of long-term care costs that covers a full range of services from nursing home to home care.

A comprehensive program, as I define it, may not make it to the drawing boards during this session of Congress. But we need to begin the process now. As I see it, such an approach must be based on three key elements:

First, it must bolster the American family's ability to do what it has been doing so well—caring for the chronically ill at home. We can start by strengthening the home health benefits that are now available under Medicare. We can also relieve some of the financial burden of care for the lowest-income families through a tax credit, similar to the credit that is available for child care.

Second, we must strongly encourage the expansion of private insurance coverage. Private insurers, frankly, have approached long-term coverage with the enthusiasm of a claustrophobic entering a crowded elevator. One route for expansion is to require that all employers make group long-term care benefits available to employees.

Third, since it is unlikely or impossible that private insurance will solve the problem and since most Americans are not going to be able to absorb the enormous cost of coverage on their own, we will also need a strong public program. Whether we expand Medicare or create a new long-term care program a comprehensive solution will be expensive. Even limiting coverage to long-term illness that extends beyond a one-to two-year period would cost of long-term protection assumes a public commitment to some broad-based revenue source. Options include raising the payroll tax, taxing estates and increasing the excise tax on cigarettes.

The agenda outlined here is not a comprehensive solution to the threat of nursing-home and other long-term care costs, Mr. Chairman. But I believe it provides a meaningful framework for beginning the process.

Senator MITCHELL. Good morning, ladies and gentlemen. Welcome to the third in a series of hearings by this committee on the subject of long-term care for the elderly and disabled.

I look forward to the testimony of the distinguished witnesses on the issues related to the financing of long-term care. Our recent discussion of the catastrophic insurance legislation in the full committee made it clear that paying for long-term care is a major concern of this nation's elderly and with good reason. For those with out-of-pocket expenses greater than $2,000 a year, 80 percent are associated with long-term care. More than half of the $30 billion in payments for nursing home care each year are paid directly as out-of-pocket expenses by the elderly or their families.

Nearly all of the remaining payments are made by the Medicaid Program, which was not designed for long-term care, but rather was intended to provide reimbursement for medical care for the poor. For the vast majority of elderly who cannot afford long-term care costs, that in some cases may exceed $25,000 a year, there is either nowhere to turn or only when they are impoverished can they receive help.

Even in States where the so-called "spend-down benefit" is available, Medicaid coverage for nursing home costs may be available only to individuals with assets under $2,000 who are permitted to retain only $25.00 a month in income.

We presently don't have a system—an effective system—of paying for long-term care, and that is neither desirable nor tolerable. Long-term care expenses, especially those for nursing home care, are large expenses and relatively unpredictable for any given individual. These characteristics suggest that insurance, either private or public or some combination of the two, should be a more effective alternative to the present inequitable situation.

Some have suggested a program limited to public insurance and financing for long-term care services; but existing budget constraints and the future growth in the elderly population in relation to those who are employed raise major concerns about a program dependent entirely on pay-as-you-go public financing. As the Social Security Program has demonstrated, the prospects for prefunding of a public sector program are not great.

Others suggest that private insurance alone can provide adequate coverage for long-term care expenses; but despite the recent rapid growth in the field, with more than 70 companies offering policies, only 400,000 Americans are now covered by private insurance.

Further, it is difficult to envision how the population most at risk for long-term care expenses—women over the age of 80—whose incomes average less than $6,000 a year will be able to afford long-term care insurance premiums that may exceed $1,000 a year.

Finally, the potential for abuse in sales of insurance to those elderly persons with the high risk of needing long-term care must be considered. The magnitude and complexity of the problem in my judgment demand the combined efforts of both the public and the private sectors.

The purpose of this hearing is to examine ways in which the private insurance industry and the public sector can work together to ensure that appropriate care is available to those elderly and disabled citizens who require nursing home care or assistance in their homes or communities. In particular, we will explore the ways in which national policy can help create a better market for private long-term care insurance, while also assuring access to long-term care for those who cannot afford private insurance and those who have exhausted private coverage where it does exist.

In this regard, I intend to introduce legislation in the near future that will expand Medicare coverage to include catastrophic long-term care expenses. At the same time, the bill will encourage the development of private insurance for those still employed in order to create significant prefunding of long-term care benefits in the future.

I am encouraged by the interest in this series of hearings on long-term care and look forward to working with my colleagues and others in response to the development of a more adequate system of long-term care service in our society.

With that, we will now turn to the witnesses. The first panel consists of Dr. Joshua Wiener, The Brookings Institution; Mr. Peter Libassi, who is Chairman of the Governor's Commission on Private and Public Responsibilities for Financing Long-Term Care for the Elderly in Connecticut; and Mr. Robert Maxwell, Vice President of the American Association of Retired Persons. Mr. Maxwell is from Crossville, Tennessee.

Good morning, gentlemen, and welcome. I will state for you and for the subsequent witnesses the committee's rules, which provide that all witnesses' statements will be included in the record in full. We ask that, to give all witnesses a fair opportunity to be heard and to give the members of the committee the chance to ask questions, that you limit your oral remarks to five minutes, that you provide a summary of those points you feel most deserve highlighting. The time is indicated by the lights immediately in front of me. As long as the green light is on, you can keep talking. When the yellow light comes on, you have a short time to stop. And when the red light comes on, that means you should sum up as best you can and permit the next witness to proceed.

We will begin with the witnesses in the order that they are listed on the agenda; and that means you, Dr. Wiener. Good morning.

STATEMENT OF DR. JOSHUA M. WIENER, PH.D., SENIOR FELLOW, THE BROOKINGS INSTITUTION, WASHINGTON, DC

Dr. WIENER. Good morning. Thank you, Mr. Chairman. While there is concensus that long-term financing reform is desperately needed, there is no concensus on what type of reform should be implemented. For the reasons that you outlined in your opening statement, I believe that neither a fully private solution nor a fully public solution is really feasible. In order to begin to solve the problems of long-term care, we need a strategy that increases the roles of both the public and the private sectors.

One option that follows this general strategy is for the public sector to provide nursing home and home care coverage through the Medicare or Medicaid Programs after a quite long deductible period, that is two or three years, and then to encourage the elderly to purchase private insurance to cover most of the deductible period. This approach is being actively discussed by several States, including Massachusetts, New York, Connecticut, Indiana, Wisconsin, and North Carolina. It is also being discussed by the Department of Health and Human Services' Task Force on Long-Term Health Care Policies, and it has emerged as a key concept in several long-term care financing bills being developed in Congress.

In order to help further the public discussion of this strategy, we simulated a version of this approach using The Brookings ICF Long-Term Care Financing Model. The details of those simulations are presented in the appendix to my testimony. The results of these simulations suggest several things.

First, although this approach is often proposed as a way to reduce public expenditures, our results suggest that public expenditures would increase rather than decrease. The cost of the expanded public coverage exceeds the Medicaid savings accruing from the private insurance covering two years of nursing home care. Viewed as a public insurance program, the incremental public costs are probably on the order of $5 to $7 billion a year and are modest compared to other, more comprehensive public insurance options.

Second, a principal assumption underlying this strategy is that shortening the coverage period for private insurance will make the insurance more affordable. This is clearly the case. Given very generous purchase assumptions, approximately 70 percent of the elderly could afford private insurance policies covering two years of nursing home care by the year 2018. This is compared to about 26 percent for policies covering six years of nursing home care. This 70 percent figure is roughly consistent with current Medigap experience and probably offers an upper bound estimate for purchase of private long-term care insurance.

This still leaves private insurance unaffordable by a substantial proportion of the elderly population. Disabled elderly will probably be unable to purchase insurance at any price. Thus, improvements in the financial protection of the Medicaid Program are crucial to ensuring that any new program benefits the lower income population as well as the upper income population. These improvements should include substantially increasing the nursing home personal needs allowance, raising the level of protected assets, eliminating spousal impoverishment, and prohibiting States from forcing sale of the home. Ideally, the welfare stigma of this income tested part of the program could be reduced by transferring it to the Medicare Program.

Another key assumption in this strategy is that the public program will induce a very strong private sector response. With the public sector covering the risky tail-end of the nursing home length of stay, the financial risks to insurers are reduced, thus encouraging them to offer policies. Indeed, this approach only makes sense if private insurers jump into the market with both feet. Otherwise, the deductible period is clearly too long for all but a minority of the elderly.

The private sector response is uncertain. Indeed, insurers are fearful of their financial risks for all parts of long-term care utilization—beginning, middle, and end.

In conclusion, given the level of expenditures that Congress seems to be willing to finance and the current round of Medicare improvements, I would have preferred to spend it on long-term care, rather than acute care. A $5 to $7 billion increase in Federal expenditures would pay for substantial improvements in long-term care coverage that would truly reduce catastrophic costs for the elderly.

Limiting the financial protection to hospital and physician costs leaves the gaping hole of nursing home and home care expenditures that even a vastly expanded private sector cannot fill by itself. In the long run, a combination of an expanded public insurance program and supplemental private initiatives provides the best hope of protecting against catastrophic costs for all elderly.

Senator MITCHELL. Thank you very much, Dr. Wiener. You have set an admirable standard for compliance with the time limits of the committee that the remaining witnesses will be hard pressed to match, but we hope they will. [Laughter.]

Mr. Libassi, welcome.

[The prepared written statement of Dr. Wiener follows:]

FINANCING LONG-TERM CARE FOR THE ELDERLY: A PUBLIC/PRIVATE PARTNERSHIP*

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*These opinions are those of the author and should not be attributed to other staff members, officers, or Trustees of the Brookings Institution.

Testimony before the Subcommittee on Health, Committee on Finance, United States Senate, Washington, D.C., June 12, 1987.

Everyone agrees that long-term care financing needs to be reformed. Nursing home costs, which can easily exceed $22,000 a year, are by far the leading cause of catastrophic health care costs. Contrary to the belief of most elderly, Medicare pays for only 2 percent of nursing home services, private insurance for less than another 2 percent. Frequently, nursing home patients use their entire life savings to pay for their care and once totally impoverished must depend on Medicaid. Public expenditures for nursing home and home care will exceed $20 billion in 1988 and are increasing rapidly. While there is consensus that long-term care financing reform is desperately needed, there is no consensus on what type of reform should be implemented.

In his report on catastrophic health care costs, Secretary of Health and Human Services Otis Bowen recommended relying solely on private sector approaches--such as private long-term care insurance and individual medical accounts--to solve the problems of catastrophic long-term care costs and rising public expenditures. While expansion of private sector financing mechanisms is desirable, our research at the Brookings Institution strongly suggests that they cannot be the total solution.

Even with extremely generous assumptions on who would participate, private sector approaches are very unlikely to finance more than a modest proportion of total nursing home and home care expenditures and will have only a very small impact on Medicaid expenditures and the number of people who impoverish themselves by spending down to the

Medicaid financial eligibility level. For example, by the year 2018, we estimate that moderately comprehensive private nursing home insurance may be affordable by at most 26-45 percent of the elderly population, may account for 7-12 percent of total nursing home expenditures and may reduce Medicaid expenditures and the number of Medicaid nursing home patients by 2-5 percent.

At the other end of the political spectrum, there are those who argue that we should have a very comprehensive public long-term care insurance program with no appreciable role for the private sector. Especially at a time when the federal government is still running massive deficits, this approach would be very expensive. In an environment where many policy-makers worry that utilization and other cost increasing factors may run rampant, this approach lacks political credibility and feasibility. Moreover, the high cost of this option is likely to require imposing significant tax burdens on moderate and lower income persons. Unless a soak the rich strategy is adopted, it is unlikely that enough revenue can be generated from the higher income population alone. Finally, although too much can be made of it, individuals should bear some personal responsibility to prepare for their own long-term care needs to the extent possible. The need for long-term care is not a rare event affecting only the few; it is a normal life event. We estimate that approximately 50 percent of all individuals reaching the age of 65 will spend some time in a nursing home before they die.

In order to begin to solve the problems of long-term care, we need a strategy that increases the roles of both the public and private sectors. The two-tiered relationship between Social Security and private pensions offers a possible model. On the first tier, we need an expanded public insurance program that will provide catastrophic financial protection for everyone. Like Social Security, the program should provide a floor which prevents individuals from becoming impoverished. It should be noted that levels of out-of-pocket costs that are considered catastrophic for people living in the community are not unreasonable for people living in a nursing home where room and board and other necessities are provided. On the second tier, private sector financing mechanisms, like pensions, should fill in the gaps and provide a higher level of financial protection for those who want it. It is likely that use of private sector financing mechanisms will substantially increase in the future and that is all to the good.

One option that follows this general strategy is for the public sector to provide nursing home and home care coverage through the Medicare or Medicaid program after a quite long deductible period (e.g., two or three years) and to encourage the elderly to purchase private insurance to cover most of the deductible period. This approach is being actively discussed by several states (including Massachusetts, New York, Connecticut, Indiana, Connecticut, Wisconsin and North Carolina) and the Department of Health and Human Services Task Force on Long-Term Health Care Policies. It has emerged as a key concept in several long-term care financing bills being developed in Congress.

In order to help further the public discussion of this strategy, we simulated a version of this approach using the Brookings/ICF Long-Term Care Financing Model, the details of the simulations are presented in the appendix to this testimony. In brief, we simulate a public nursing home insurance program under Medicare with a two and a three year deductible and 10 percent coinsurance. At age 67, the elderly are assumed to buy one of the currently available private insurance policies to fill in all but 20 days of the long deductible period, if they can afford it at 5 percent of their income and if they have at least $10,000 in nonhousing assets. These private policies provide a nonindexed nursing home indemnity benefit of $50 a day.

Several implications can be drawn from this simulation. Although this approach is often proposed as a way to reduce public expenditures, our results suggest that public expenditures would increase rather than decrease. This is largely because the expanded public coverage exceeds the Medicaid savings accruing from private insurance covering two or three years of nursing home care. The incremental public costs are modest compared to other, more comprehensive public insurance options. Incremental public expenditures could be minimized by raising the cost-sharing, but higher coinsurance will increase the proportion of nursing home residents who impoverish themselves to Medicaid levels. Income-related coinsurance can help mitigate this problem.

A principal assumption underlying this strategy is that by shortening the coverage period, private insurance will be more affordable. This is clearly the case. Given generous purchase assumptions, 70 percent of the elderly could afford private insurance policies lasting two or three years in 2018, compared to 26-45 percent for policies covering six years of nursing home care. This is roughly consistent with the current Medigap experience and probably offers a high upper bound estimate for purchase of private long-term care insurance. Unfortunately, existing private insurance products have many restrictions (e.g., prior hospitalization requirements, pre-existing condition exclusions, indemnity benefits that are not indexed to inflation) that limit the level of financial protection that they offer. Improving coverage will increase the premium price and reduce affordability.

Even with existing insurance policies, private insurance will still be unaffordable by a substantial proportion of the elderly population. Disabled elderly will probably be unable to buy insurance at any price. For the substantial proportion of elderly unable to purchase insurance, the $44,000-$66,000 deductible will be far too high and the only option will be to impoverish themselves down to Medicaid levels. Thus, improvements in the financial protection of the Medicaid program are crucial to ensuring that the new public program does not benefit only the better off elderly. These improvements should include substantially increasing the nursing home personal needs allowance, raising the level of protected assets, eliminating spousal impoverishment, and prohibiting states from forcing sale of the home. Ideally, the welfare stigma of this income-tested part of the program could be reduced by transferring it to Medicare.

Another key assumption in this strategy is that the public program will induce a very strong private sector response. By clearly defining a gap not covered by the public program, the marketing costs of private insurance should be reduced. Moreover, with the public sector covering the risky "tail end" of the nursing home length of stay, the financial risks to insurers are reduced, thus encouraging them to offer policies. Indeed, this approach only makes sense if private insurers jump into the market with both feet. Otherwise, the deductible period is far too long for all but a small minority of elderly. The private sector response is uncertain. My own discussions with insurers suggest that while the financial risk of the tail end of the nursing home length of stay is of concern, they have already limited their risk by offering policies that only cover a fixed period (e.g., four years). Indeed, they are fearful of their financial risks for all parts of long-term care utilization--beginning, middle and end.

Another option that builds on the idea of a public/private partnership is to develop a public insurance program that provides a broader set of benefits than the long deductible program, but still contains substantial cost-sharing. Private insurance would fill in the deductibles and coinsurance for those who chose to buy it. This strategy is more like the acute care Medicare program (with higher levels of cost-sharing) supplemented by private Medigap policies. By lowering the levels of cost-sharing (compared to the very high deductible program discussed above), the risk of impoverishment would be reduced, especially if combined with improved financial protection for the lower income population. This approach also retains a substantial role for the private sector, but does not depend wholly on massive expansion of private insurance for its success. Its principal drawback is that public expenditures would be substantially higher than the less comprehensive public program alternative.

In conclusion, the proposals by Secretary Bowen to improve the financial protection against catastrophic health care costs by expanding Medicare coverage are a step in the right direction. Given the level of expenditures that Congress seems willing to finance in the current round of Medicare improvements, I would have preferred to spend it on long-term care rather than acute care. A $5-7 billion increase in federal expenditures could pay for substantial improvements in long-term care coverage that would reduce truly catastrophic costs for the elderly. Limiting the financial protection to hospital and physician costs leaves the gapping hole of nursing home and home care expenditures that even a vastly expanded private sector cannot fill by itself. A combination of an expanded public insurance program and supplemental private initiatives provides the best hope of protecting against catastrophic costs for all elderly.

CATASTROPHIC PUBLIC INSURANCE (CATIN1 AND CATIN2)

This proposal combines public and private insurance. The public insurance would provide substantial catastrophic coverage only after a relatively long period in a nursing home. However, the sharply defined "window of vulnerability" would encourage private insurance companies to offer Medigap-like, fill-in policies.

Assumptions

- The public insurance would have nursing home benefit with a two year deductible and 10 percent coinsurance. Reimbursement rates would be 115 percent of the Medicaid rates.

CATIN1

- Under CATIN1, there is only public insurance. There is no private insurance. This allows us to estimate the independent effect of the public insurance compared to the combination of public and private insurance.

CATIN2

- Under CATIN2, public expenditures are included in the Medicare category.
- With CATIN2, elderly individuals and couples may purchase private insurance to supplement their public insurance. Based on one of the currently marketed plans, this private insurance policy has a 20 deductible and covers a maximum of two years in a nursing home. It provides a nonindexed benefit of $50 a day (in 1986 dollars). In 1986 dollars, premiums start at $473 at ages 65-69 and rise to $1,256 at ages 75 to 79.
- Individuals and couples buy the private insurance only if they can afford it for 5 percent or less of their income and if they have $10,000 or more assets. The assets provision assumes that insurance will be purchased only if there are at least minimal assets to be protected. All individuals who meet the income and assets tests purchase insurance.
- If an individual's income declines after purchasing the policy or does not keep up with the cost of the policy so that the premiums are no longer less than 5 percent of income, we assume that the individual will continue purchasing the policy so long as the premiums are less than 7 percent of income and the individual/couple has $10,000 in assets.
- Following insurance industry policy, no one who is disabled will be

allowed to make an initial purchase of a policy. Individuals who become disabled after they have the policies will continue to hold the policies.

- In 1986, individuals age 67-81 will be eligible to purchase the policy. After 1986, individuals will purchase the policies starting at age 67.
- After 1986 the initial indemnity benefit increases with the CPI plus the Social Security Administration's II-B assumptions about growth in real compensation (1.8 percent over the CPI). Premiums for the policy increase at the same rate.

Results: CATIN1

- By 2016-2020, the catastrophic public insurance plan accounts for $46 billion or 46 percent of total nursing home expenditures. Compared to the base case, Medicaid expenditures decline by 57 percent. The catastrophic public insurance plan reduces private expenditures from cash income by 34 percent and from assets by 31 percent.
- By 2016-2020, compared to the base case, the number of Medicaid nursing home patients declines by 25 percent.

Results: CATIN2

- By 2016-2020, 72 percent of the elderly have private insurance to supplement their public coverage.
- By 2016-2020, the combination of public and private insurance accounted for $64 billion or 63 percent of total nursing home expenditures. The private insurance accounted for $19 billion or 18 percent of total nursing home expenditures and the public insurance accounted for $46 billion or 45 perecent of total nursing home expenditures.
- By 2016-2020, compared to the base case, the combination of public and private insurance reduces Medicaid expenditures by 65 percent. This is 8 percentage points more than under the public program alone.
- By 2016-2020, compared to the base case, the combination of public and private insurance reduces the number of Medicaid nursing home patients by 37 percent. This is 12 percentage points more than the public program alone.
- By 2016-2020, on an admission cohort basis, the public program (i.e., the medicaid column equally covers all demographic (age, sex and

marital status) and income groups. The private insurance is disproportionately a source of nursing home financing for the young elderly, males and married couples and upper income groups. Medicaid expenditures are disproportionately reduced forthe old-old, females, unmarried and lower-income groups.

STATEMENT OF F. PETER LIBASSI, CHAIRMAN, CONNECTICUT GOVERNOR'S COMMISSION ON PRIVATE AND PUBLIC RESPONSIBILITIES FOR FINANCING LONG-TERM CARE FOR THE ELDERLY, HARTFORD, CT

Mr. LIBASSI. Thank you, Mr. Chairman. I will speak twice as fast now. [Laughter.]

I am here today in my capacity as Chairman of Governor O'Neill's Commission on Private and Public Responsibilities for Financing Long-Term Care for the Elderly. I am also a Senior Vice President with The Travelers Insurance Company. I am accompanied by Georgina Lucas, who was the Staff Director of Governor O'Neill's Commission, Ken Kooz, a tax partner for Coopers and Lybrand, who is the author of the Commission's report on tax issues related to long-term care; and Dave Pustilnik, who is tax counsel for Travelers and also active in health and life insurance associations.

I will skip the findings of the Commission and go right to the conclusions. We came to three basic conclusions. First, no single institution in our society—no segment of our society—can in fact meet the long-term care financing issues alone—not the family, not the individual, not insurers and employers, not the service providers, state government or federal government. All of these segments in our society have an obligation and an important role to play in a collaborative effort to meet the issues of financing long-term care.

The second conclusion was that a combination of strategies will be needed to provide the services that we are discussing.

The third conclusion we reached is that the problem of financing long-term care is not a financing problem. It is a service delivery problem. It is a health promotion problem. It is a research and training problem, and it is a data collection and consumer protection problem.

We must not approach the issue of financing long-term care exclusively as a financing issue. Several strategies will be needed to address this complex set of issues at the same time. We made six recommendations.

First, there is a need for the State to encourage the expansion of private long-term care financing options. Second is the need to expand home and community-based services. It is important both to increase the financial resources in the system, and at the same time to increase the services that are provided.

The third strategy is that the states should encourage long range approaches to maintaining a healthy future for the elderly. We need to simultaneously work with improving the health and well-being of the elderly and thereby reduce their need for long-term care. The fourth recommendation is to expand consumer education and consumer protection efforts, and the fifth is to improve data collection.

There is a serious lack of longitudinal data on service utilization, service delivery systems, financing, spend-down, etcetera. The lack of this data is an important limitation on our ability to develop financing options and also to develop service delivery systems.

And finally, we called on the State to enlist federal action in support of state and private initiatives; and certainly, the expansion of the Medicaid Program is a critical part of the federal role. We do not see any way in the future for the Medicaid Program to be reduced by any public and private cooperative efforts, and we would see an expansion of the $15 to $17 billion the federal government now spends.

For the federal government, tax incentives are the most obvious way by which the federal government can encourage private financing. And I think, Mr. Chairman, your amendment in calling on the Treasury Department for a tax study of long-term care issues is a very positive development.

We believe that tax incentives are needed to encourage the development of group insurance as a way of stimulating the private market. In addition, in light of the essential role that the family plays in providing long-term care, we hope that that study will include a look at which federal tax policies can be modified to encourage and support those families that are now bearing the burden of caring for the elderly, both in their homes and in the community.

Another federal role is to improve the health and well-being of the elderly. Rather than reducing federal support as has been proposed, Congress should be expanding the funding for geriatric research and for training of health professionals in the field of aging. It is very distressing for families who, when they find services that are available in the community, learn that the quality of the professional and paraprofessional staff is not adequate to provide the services needed. So, training and research are two very important roles for the federal government.

And finally, I would hope that the federal government would look more favorably on applications for Medicaid and Medicare waivers so that the states that are interested in testing new models for the financing of long-term care may go forward.

I believe that the ideas for public/private cooperation in the financing should be strongly supported by federal waivers. And without establishing any new entitlement programs requiring major new outlays in federal revenues, we believe that the federal government can continue and enhance its essential role in shaping a more humane, a more cost effective, and rational system for providing care for the elderly. Thank you, Mr. Chairman.

Senator MITCHELL. Thank you. Mr. Maxwell, two witnesses in a row have finished in less than five minutes. That puts tremendous pressure on you.

Mr. MAXWELL. That is going to be a challenge. [Laughter.]

Senator MITCHELL. Before I call on you, I would like to acknowledge the presence of two of my colleagues and ask if they have any opening remarks they care to make. Senator Durenberger, as we all know, served with great distinction as chairman of this subcommittee for six years. He is responsible for much of the improvement in the area of health care in this country in this decade; and I am very pleased he is here to join us and I look forward to working with him on this and other health issues. Senator, do you have an opening statement you care to make?

Senator DURENBERGER. Mr. Chairman, I do not have a formal statement, but I would be remiss if I didn't applaud you. And I think the respect we all have for George Mitchell is reflected in the fact that this is part of a three-hearing process on a subject that all of us know little about. I have been trying for five years just to define the term "long-term care," Mr. Chairman, and it is difficult to do.

The more change that comes in the health care delivery system, the more we find that there are areas we don't understand and we need to tackle them. My mail in Minnesota on catastrophic all reflects the fact that the elderly in my State have their deepest concerns for nursing home care and how that is going to be financed. So, their version of catastrophic is running out of money before they can find the appropriate care in the system.

So, doing this work, Mr. Chairman, is noble; and I congratulate you for the time you are able to put against it and have all the rest of us put against it, given the heavy agenda you carry.

Senator MITCHELL. Thank you very much, Senator Durenberger. Senator Riegle?

Senator RIEGLE. Thank you, Mr. Chairman. I, too, appreciate the leadership that you have shown. We certainly have an enormous and growing problem with respect to financing long-term health care in this country. Just two weeks ago, I had a public hearing in the State of Michigan under the auspices of the Budget Committee to look at the question of catastrophic health care needs.

We invited residents of an area around Warren, Michigan to the hearing. And I must say to the chairman and to those present who have a particular interest in this field that on Monday morning at 10:00 we had over 1,000 people attend; People waited all day to testify to a standing room only audience.

We took testimony from well over 100 citizens, in addition to a panel of experts who we had invited to speak. That testimony and the early responses we are getting from it reveal that this is an incredibly fast-growing problem in this country.

John Naisbitt, the author and lecturer, has said that over 2.3 million Americans are 85 or older and that by the year 2000, we will have 5.4 million Americans aged 85 or older. By the year 2000, an estimated 7.5 million Americans will be aged 85 or older. Meeting the health care needs and the long-term care needs of persons of such advanced age will present a challenge to this country of a magnitude and importance that we have only just started to address.

So, these hearing today, and the ones to follow, are very important. I am particularly interested in the testimony we are hearing from our witnesses today and others that we will be hearing from later today and in the future.

So, with that, Mr. Chairman, I hope to be able to introduce you to a panel of experts that we had asked to speak first. And what developed from that testimony and other such meetings as we are now planning them around the State, and the early responses that we are getting, are that this is an incredibly fast-growing problem in the country.

I think John Nesbitt, the author and lecturer, has estimated that we have something on the order of 12,000 or so people today in this country above the age of 100—if I am remembering the data properly—and it is estimated that by the year 2000, we will have 1,200,000 people above the age of 100 in our society. And if you think about that, not just in terms of that age group, and the requirements of meeting the health care needs and the long-term care needs of persons of advanced age like that, but everybody who will be post-retirement, but up to 100, the growth all along that curve. It is just a phenomenal change in national circumstance, and the health care needs, both in terms of quality and cost, I think, present a challenge to this country of a magnitude and importance that we have only just started to think about.

So, these hearings today are very important and the ones to follow; and I am particularly interested in the testimony that we are hearing from our witnesses today and others that we will be hearing from later today and in the future.

So, with that, Mr. Chairman, I hope to be able to help you and others find answers in this area.

Senator MITCHELL. Thank you very much, Senator Riegle. Senator Chafee?

Senator CHAFEE. Thank you, Mr. Chairman. I want to also commend you for having these hearings. What we are really talking about here is the number one concern of the elderly. Certainly the elderly that I talk with the number one concern is long-term care. They feel the hospitalization is taken care of, but it is what happens when they have to go into a nursing home. And the lifetime risk of having to enter a nursing home is about 20 percent; and at any one time, five percent of all elderly individuals are in nursing homes, the average cost of which is about $22,000 a year.

Now, for most of the elderly, the risk of needing long-term care and entering a nursing home, as I say, is their most paralyzing fear. It certainly is from folks in my section of the country, and they have good reason to be concerned. These statistics are just mind-boggling. One-half of all nursing home payments are out-of-pocket expenditures, and almost all the rest are paid by Medicaid. Approximately one-half of all Medicaid recipients were not initially poor. They go into a nursing home with some money they have saved carefully over their years, and then they spend down—they use up their monies—and then go on to the Medicaid Program.

And of course, under the current definition of Medicaid and the way the system functions, you have to have limited income and resources before you become eligible. So, I hope we can get some solutions in all of this.

And as you recall, Mr. Chairman, two weeks ago we considered the catastrophic health care bill. Many of us here expressed concerns that it didn't deal with the long-term care, and that is what we are tackling today; and I am very glad we are doing it. Thank you.

Senator MITCHELL. Thank you very much, Senator Chafee. Mr. Maxwell, the members of this committee and indeed the Members of Congress are very respectful of the organization you represent, those twenty five million Americans; and as always, we look forward to your testimony.

[The prepared written statement of Mr. Libassi follows:]

STATEMENT

of

THE CONNECTICUT GOVERNOR'S COMMISSION
ON
PRIVATE AND PUBLIC RESPONSIBILITIES
FOR
FINANCING LONG TERM CARE FOR THE ELDERLY

Before the
SUBCOMMITTEE ON HEALTH
of the
FINANCE COMMITTEE
U.S. SENATE

on

"FINANCING OF LONG TERM HEALTH CARE"

June 12, 1987
Washington, D.C.

Presented by
F. Peter Libassi
Chairman

Good morning, Mr. Chairman and Members of the Committee. I am F. Peter Libassi, Chairman of the Connecticut Governor's Commission on Private and Public Responsibilities for Financing Long Term Care for the Elderly. I am also senior vice president for corporate communications at The Travelers Companies.

I am pleased to have been invited to report on the findings of the Commission's study as well as on the Governor's Action Plan designed to implement the Commission's final recommendations.

In anticipation of the potential crisis in long term care, Governor William A. O'Neill appointed the Commission on Financing Long Term Care in June 1986. The Governor charged the Commission to assess the long term care financing needs in Connecticut, to evaluate our current system of financing long term care for the elderly, and to propose new financing methods. He especially sought to identify ways the State could work with the private sector to increase private sector support in financing long term care for the elderly.

After a year of research and a series of public hearings we have issued a report identifying the impediments to private financing and suggesting strategies to minimize or overcome them. Our recommendations focused on State leadership to stimulate action at the state and federal levels, in the private sector, and in the community. My following remarks highlight the findings, conclusions, and recommendations of our report.

The financing of long term care is rapidly emerging as one of the most serious challenges facing this country. This issue's sudden ascent in importance has occurred because a number of social and economic trends are coming together to create the potential for a silent social disaster. These factors are creating significant pressures on state and federal government, on business and community institutions, and on our individual citizens and families.

The most significant factor is the "greying" of our population, particularly the increases in numbers of those 85 years of age and older who are most likely to require long term care. The demographic projections in Connecticut roughly parallel those for the nation. From 1980 to the year 2000, the number of Connecticut residents age 65 and older will grow by 41 percent, while the state's population as a whole will grow by only 9 percent. By 2000, nearly one-half of those age 65 and older, will have reached age 75 (48 percent).

Between 1980 and 2000, the number of elderly in Connecticut age 75 to 84 is projected to increase by 70 percent, from 3.5 percent of the total population to 5.5 percent of the total population. Those aged 85 years of age and older will increase by 67 percent, from 1.2 percent of the total population to 1.8 percent of the total population. By the year 2000, those age 75 and older will constitute 7.3 percent of our population.

Other factors contributing to the growing urgency of the long term care problem include changing family structures, such as the increased prevalence of family members living far apart, divorces and two-worker families, the current limited range of options for financing long term care, a public policy bias toward care provided in institutional settings, and the lack of financial preparedness of individuals and families to meet long term care needs. Adding to the problem is the enormous misconception that there already exists a system for financing long term care through Medicare, when no such system exists.

The greying of Connecticut's population will result in an unprecedented increased need for both acute and long term care services over the next 13 years. In Connecticut, by the year 2000, we project a 44 percent increase in the number of physician visits by the state's elderly, a 31 percent increase in the number of acute hospital days consumed by the state's elderly, a 42 percent increase in the number of Connecticut elderly residing in skilled and intermediate care nursing homes, and a 53 percent increase in the number of elderly receiving skilled health care, personal care, and homemaker services at home.

These projections for long term care require us to address the adequacy of our resources both to deliver and to finance future long term care services.

Currently, it is estimated that over 80 percent of all long term care services are provided by families and friends. This resource is crucial for three reasons: Older persons prefer to be cared for at home by loved ones; informal care is provided without expense to the public sector; and informal care often delays or precludes the use of formal services thus relieving demands on the long term care delivery system. In fact, the primary determinant of institutionalization versus care in the community is the availability of assistance from others, not the severity of illnesses or functional impairments.

Formal long term care services are provided through a loosely-organized, partially-integrated system of service providers, including long term care facilities, home care agencies, adult day care centers and other community-based support services. However, the current rate of growth in formal service capacity is not adequate to meet projections of future needs.

Just as the delivery system will not have the capacity to meet future needs, the financing systems will likewise not be adequate to the challenge. The stark reality is that individuals and families pay for long term care from savings and available income until their resources are exhausted. At that point, the State Medicaid program begins paying the bills for nursing home care and some community-based services.

In fact, approximately 54 percent or $318 million of the State's $585.1 million 1987 Medicaid budget is earmarked for health care of the elderly. Of this $318 million, $274 million will go for long term care in nursing homes. This nursing home bill represents 5.6 percent of the total state budget. If patterns of care and financing are not modified by the year 2000, these costs for nursing home care will rise from $274 million to $1.4 billion, or 7.9 percent of the state budget.

Individuals and families pay most of the remaining bill for long term care, with other public programs and private insurance contributing little. This causes tremendous hardship for those unfortunate people in need of services. In 1984, of the $30.2 billion of out-of-pocket health care expenditures incurred by the elderly, 42 percent, or $12.7 billion, went for nursing home care. That amount represents the impoverishment not only of thousands of individuals, but sometimes their spouses as well.

When a married nursing home resident is Medicaid eligible, the community-residing spouse is allowed a monthly income of only approximately $350 from their joint resources. This is not an adequate income upon which to survive.

The current long term care financing system, which leads people either to impoverishment or to gaming the system by transferring assets, and which results in inappropriate institutionalization, is irrational, inequitable, and inadequate. This system came about by default not by design.

The challenge to the State is to design a comprehensive, coordinated system which will moderate the growth in State expenditures for long term care, assist families to meet their long term care financial needs, and assist families to find the care services needed by the elderly and their families. The complexity of the long term care financing issue requires a multifacted response.

No single element of society -- neither the individual, the family, employers, insurers, service providers, state government, nor the federal government -- can meet our overall long term care financing needs alone. They must all participate collaboratively in addressing the long term care needs of today's and tomorrow's elders.

In addition, a combination of strategies is essential if we are to provide the array of services necessary to meet the needs of the elderly in an efficient and cost-effective manner. The problem of financing long term care is not just a financing problem. It is a financing problem, a service delivery problem, a health promotion and research problem, a data collection, and a consumer education problem.

The Commission concluded that better methods of public and private financing of long term care are needed, that the delivery system -- particularly community-based services -- must grow to accommodate our demographic shifts, and that long-range preventive measures must be taken to improve the well-being of future generations of elders and to contain the costs of caring for them.

We made recommendations in five broad categories:

1. The variety and availability of new methods of private long term care financing should be increased to meet the demands of diverse market segments and to moderate the increase in pressures on public treasuries at the state and federal level. These methods include home equity conversion, insurance, health maintenance organizations, continuing care retirement communities, and other innovative alternatives. The more private financing options which are available, the greater will be the opportunity to avoid the negative consequences of the present system -- spousal impoverishment, asset transfer, and growing public liability.

   Similar to action being considered at the federal level by the Office of Personnel Management, the Governor plans specifically to offer long term care insurance to State employees to set an example for other employers. In addition, he plans to convene Connecticut business and labor leaders to focus attention on employer sponsorship of long term care benefits and other business implications of a growing elderly population.

   The Governor has directed appropriate State agencies to expand the flexibility of current State-sponsored home equity conversion programs and to remove current barriers to the use of home equity conversion now inherent in our Medicaid eligibility standards.

In addition, the Office of Policy and Management has responded to an invitation from the Robert Wood Johnson Foundation to submit a grant proposal for the exploration of public and private partnerships in financing long term care. A favorable disposition of our proposal is hoped for in July, at which time data collection and analysis efforts will begin, with simulations of various proposals to follow.

2. The availability of and financing for home and community-based alternatives must be expanded. These home and community-based services complement and sustain family caregiving efforts and, as an alternative to institutional care, represent savings to the individual, the family, and potentially the public sector.

As financing options are created, available services with appropriate cost controls must also be expanded. The Governor plans to begin encouraging the development of community-based alternatives by expanding Medicaid coverage of adult day care.

In addition, new techniques for controlling costs, and for managing the appropriateness and quality of long term care services are being expanded. In Fairfield County, Connecticut, pre-admission screening of Medicaid-eligible hospital patients awaiting nursing home placement has led to the successful diversion of 24.4 percent of them to community-based care. With case-management these individuals have been cared for in the community at a monthly savings of $778 compared to expected costs for institutional care. Pre-screening and case-management for Medicaid-eligible nursing home candidates will be expanded statewide this year.

3. Long-range strategies must be developed and supported to enhance the personnel resources available to meet long term care needs and to moderate the increase in demand for long term care services. These positive long range strategies should include the extended employment of older adults, disease prevention and health promotion, expanded support of research into the diseases of old age, and expanded support for the training of health care professionals.

   Increased financing options and expanded service delivery systems will not be sufficient if we do not simultaneously work to reduce the numbers of elderly who will be in need of long term care in the future.

4. Consumer education programs regarding long term care financing should be expanded. A more educated populace will understand the need for timely personal financial planning efforts. Furthermore, consumer education, together with an effective program of consumer protection, will enable individuals to make selective, informed choices. As a consequence, traumas such as spousal impoverishment may be reduced and pressure for public support moderated.

   The Governor has directed the State Department on Aging to enhance its current educational efforts and to collaborate with other State departments in establishing public education outreach programs. Similarly, the Departments of Insurance and Consumer Protection have been instructed to intensify public education and consumer protection programs.

5. Data collection efforts and public dissemination of information regarding long term care service utilization must be improved. The lack of data, particularly longitudinal data which describes long term care service utilization over time, presents design and product-pricing difficulties for government, providers, insurers and other entities which may provide long term care risk-sharing, e.g. health maintenance organizations and continuing care retirement communities.

   Information is the key to managing risk, and its availability will therefore expedite the entry into the market of both more products and more product sponsors.

   The State has already undertaken projects to coordinate access to the data collected by 13 State health and social service agencies and to analyze its existing long term care data base.

The Commission also recommended to the Governor that federal action in support of state and private initiatives be enlisted. The federal government has played and continues to play an important role in providing health care for the elderly. Among other things, the federal government supports nursing home care through the Medicaid program at a cost of approximately $15 billion per year, thereby meeting one-half of the public sector's share of the nation's nursing home bill for the elderly. Given the projected increase in demand for health care services, however, this level of funding not only must continue, but it must increase and it must be supplemented by additional federally-funded health care strategies.

While the current political climate and the realities of decades of federal deficit spending impinge upon the ability and the inclination of the federal government to play a leadership role in responding to the impending crisis in long term care financing, a federal role is integral to the ultimate resolution of the problem. A response by Connecticut alone or by a collection of states cannot be sustained without complementary national initiatives.

Consequently, Governor O'Neill will work with the Connecticut congressional delegation, other members of Congress, and the National Governor's Association to strive for an appropriate and expanded federal response.

Tax incentives are the most obvious means by which the federal government can encourage private financing of long term care. There are currently very limited financial incentives for the private financing of long term care through savings, insurance, family contributions or family caregiving.

By creating tax incentives and removing tax barriers to new, as well as existing, private methods of financing long term care, employers, individuals, insurers and other financial institutions will be encouraged to expand their roles in long term care.

In view of the essential role families play in providing informal long term care services to their elders, the federal government should expand incentives and support for these family efforts. Current tax incentives for family caregiving are very difficult to qualify for because of the restrictive definitions and tests of "dependency." Modifications to the tax code should be made to facilitate the use of tax advantage programs, thereby creating incentives for, or in some cases, financially enabling, family members to care for their elders.

The federal role also should include an expansion, rather than the retrenchment we have experienced in the past few years, of federal funding in the field of geriatric research and the training of health professionals in the field of aging. The federal government also must expand its activities in the areas of health promotion and disease prevention, which will help the elderly retain their well-being later in life and will help to contain the costs of their care. Finally, the federal government must look more favorably on applications for Medicare and Medicaid waivers from those states interested in testing new models of long term care delivery and financing.

Connecticut, for example, because of its size and the depth of its financial, business, and intellectual resources, would be an ideal site for demonstrating alternative financing and delivery models. And the State is interested in playing a leadership role in this capacity.

Without establishing any new entitlement requiring major new outlays in federal revenue, the federal government can continue and enhance its essential role in shaping a more humane, cost-effective, rational system of providing and paying for long term care.

STATEMENT OF ROBERT MAXWELL, VICE PRESIDENT, AMERICAN ASSOCIATION OF RETIRED PERSONS, CROSSVILLE, TN

Mr. **Maxwell.** Thank you, Senator. I am Vice President of the American Association of Retired Persons. On behalf of our some 25 million members, I want to thank you for this opportunity to state the association's views on long-term care financing because there are few, if any, issues of more pressing concern to older Americans.

Older people or their relatives are bearing the brunt of practically all of the costs of community-based long-term care, and they are paying more than half of our nation's nursing home bill. In a public opinion poll conducted for AARP in the fall of 1986, 82 percent of Americans aged 45 and older said they would favor a Government program to help pay for long-term nursing home costs for persons not covered by Medicaid. The long-term care insurance market is still in its infancy.

According to a recent estimate, there are presently only about 400,000 long-term care policies in force. While it is true that this market will grow, we should not harbor unrealistic expectations about its potential, especially in the short run. The ability of insurers to accurately predict and price the risk of future long-term needs remains limited, and few if any are comfortable enough with their policies or their pricing to aggressively market the coverage.

Many of the products on our market today have significant restrictions and exclusions. Some are restricted to skilled care; others are not indexed for inflation; still others require prior hospitalization, which may deny coverage to Alzheimer's patients and others. Perhaps most important, current long-term insurance is inaccessible to many older persons due to cost and underwriting restrictions.

Few insurers will sell to those over age 80, and persons with potentially disabling medical problems are not eligible for most of the insurance plans. Private long-term care insurance has major market problems. Most people seriously underestimate the risk of needing long-term care. Others may deny that they might ever be confronted with a disabling illness. Many younger, as well as older, persons feel they simply cannot afford the premiums.

In the longer run, employer-based long-term care insurance may be able to significantly increase affordability and availability. Few younger workers, however, recognize the potential risk of needing such services. AARP is working to overcome obstacles to developing viable long-term care insurance policies. In conjunction with Prudential, we have offered to eligible members in certain States a test marketed policy; and over 9,000 of our members have purchased the coverage. We will be offering our plan to our members nationwide this summer, and we are doing so because private insurance helps to meet the real need of older persons in the absence of better Government protection.

A recent survey indicates that the primary reason for purchasing the plan was the need for security and protection. Nonbuyers erroneously believe that Medicare, employer-based group insurance, or Medigap policies cover long-term care.

Cost was also a significant reason for not buying the plan. These findings are important and AARP wants to emphasize that more work must be done before anyone will have even a basic understanding of market demand and acceptance of long-term care insurance.

A number of proposals for Government support of the long-term care market are being discussed, most of which involve the creation of tax incentives for consumers or insurers of long-term care products. Exempting interest on long-term care insurance reserves from taxation is a proposal which deserves consideration. Other proposals are more problematic.

Tax incentives for IMAs would primarily subsidize wealthier persons who are most able to afford existing policies. Tax credits for the purchase of long-term care insurance would not apply to the majority of persons over 65 who are not required to file income tax returns. Proposals to direct accumulated pension funds towards the purchase of long-term care insurance could potentially endanger the funding of private pension plans.

Before such measures are enacted, we should consider whether private insurance can provide adequate and affordable coverage to all or even most citizens. If not, we must determine whether Government subsidies to promote private coverage are warranted or whether these revenues would be better directed toward a more comprehensive public effort.

With private long-term care insurance, while it is a viable option for some Americans, it cannot be a panacea to the long-term care financing program. It is essential for the Government to play a much stronger role in financing long-term care and it is essential that this not lead to second-class systems of care for the very old and uninsurable.

Senator MITCHELL. Thank you very much, Mr. Maxwell.

[The prepared written statement of Mr. Maxwell follows:]

AARP

STATEMENT

of the

AMERICAN ASSOCIATION OF RETIRED PERSONS

on

LONG TERM CARE FINANCING

Presented by:

Robert Maxwell, Vice President

before the

SENATE FINANCE COMMITTEE
Subcommittee on Health

Washington, D.C.
June 12, 1987

American Association of Retired Persons 1909 K Street, N.W., Washington, D.C. 20049 (202) 872-4700
John T. Denning *President* Cyril F. Brickfield *Executive Director*

Introduction

Thank you, Senator Mitchell. My name is Robert Maxwell. I am the Vice President of the American Association of Retired Persons (AARP). On behalf of the more than 25 million members of AARP, I want to thank you for this opportunity to state the Association's views on long term care financing. Before I begin, however, I would like to say that the Association is very pleased that this Subcommittee has chosen to take a close look at the problem of long term care financing. There are few, if any, issues of more pressing concern to older Americans.

I will focus my remarks this morning on four areas: (1) the burden of long term care expenses on older persons and their families; (2) the potential of private long term care insurance to solve the problem; (3) proposals for government support for private insurance; and (4) the need for a strong public sector role in financing long term care.

The need for long term care creates an often insurmountable financial burden for individuals and families. One response to this problem is to encourage the development of private health insurance. In recent months a great deal of discussion has focused on how government policy can improve the market for long term care insurance. Given the large federal budget deficits and the tough spending decisions facing this country, it is not surprising that many have looked to the insurance industry to answer the question of how to finance long term care. Before measures to promote the efforts of private insurers are enacted, however, we should consider whether private insurance ever can provide adequate and affordable coverage to all or even most citizens. And, if the answer is that it cannot, we must determine whether government tax subsidies and other efforts to promote private coverage are still warranted, or whether these revenues would be better directed toward a more comprehensive public effort.

The Burden of Long Term Care Expenses on Families

1. Community Based Long Term Care

Older people or their relatives are bearing the brunt of practically all of the cost of community-based long term care. The vast majority of long term care (71%) is provided in the community rather than in institutions. Family members are the cornerstone of the long term care delivery system. According to the 1982 National Long Term Care Survey, almost 3 out of 4 functionally impaired older Americans rely exclusively on unpaid sources of care provided by families and friends, and another 21% on a combination of support from families and paid providers. Only 5% of the elderly rely solely on paid providers, and only a small proportion of this paid care is financed through government sources.

2. Nursing Home Care

By far the most devastating health care expense for older Americans is that of long term, chronic illness. Nursing home stays account for over 80% of the expenses incurred by older people who experience very high out-of-pocket costs for health care (over $2,000 per year.) Indeed, the amount older persons paid out-of-pocket for nursing home care in 1986 exceeded the amount they paid out-of-pocket that year for all hospital inpatient care, physician services, and drugs combined. As indicated in Figure 1, Medicare and private insurance combined pay only a miniscule proportion of nursing home costs (less than 3% in 1985). More than half of nursing home costs are paid out of the pockets of residents or their families. Most of the remaining costs are paid under Medicaid.

It is not generally recognized that the proportion of total nursing home costs being paid out-of-pocket has risen substantially in the last decade, i.e., from 42.7% in 1975 to 51.4% in 1985 - an increase of about 20%. (At the same time, the proportion of nursing home costs funded by Medicaid and Medicare has been decreasing.) In absolute terms, the amount Americans were paying out-of-pocket for nursing home care rose from $4.3 billion in 1975 to $18.1 billion in 1985, an increase of 420% Even when this is corrected for inflation, out-of-pocket spending still more than doubled.

Given the magnitude of the burden on older persons and their families, it is not surprising that there is growing support for change. In a public opinion poll conducted for AARP in the fall of 1986, 82% of Americans aged 45 and older said that they would favor a government program to help pay for long term nursing home costs for persons not covered by Medicaid; 72% went on to say that they would still favor such a program if it meant a small cost to them to finance it. When asked how they thought such a program would be financed, the single largest response (37%) was "taxes." Thus, by a wide margin, middle aged and older Americans believe that the government should assume greater responsibility for long term care financing, and the majority express willingness to make some sacrifice to assure that coverage is available.

Potential of Private Insurance to Solve the Problem

The long term care insurance market is still in its infancy, although it shows signs of growth. According to a recent estimate, there are presently over 400,000 long term care policies in force, double the number estimated only two years ago. Recent public attention focused on the lack of financial protection for long term care has encouraged insurers to seriously consider this market, and at least 30 companies now have long term care products available.

While it is true that this market will grow, we should not harbor unrealistic expectations about its potential, especially in the short run. The ability of insurers to accurately predict and price the risk of future long term needs is limited. Although many insurers are "interested" in this market, few, if any, are comfortable enough with their policies or their pricing to aggressively market the coverage. Most companies are going very slowly, establishing market "presence", but avoiding significant market penetration. Even if the number of persons covered by long term care insurance contracts triples in the next few years, a significant feat, only a very small fraction of those at risk will have coverage.

Many of the policies on the market today have significant restrictions and exclusions that limit their effectiveness. Plans are generally not indexed for inflation and hence may fail to keep up with the escalating costs of care. Many plans require a substantial deductible. Policies which require a prior hospitalization before covering a nursing home stay can effectively deny coverage to Alzheimer's patients and others whose need for long term care services may not begin with an acute care episode. Some policies cover only skilled nursing home care. Non-skilled home care may not be covered at all, or a long nursing home stay may be required in order to trigger home health benefits. Often, buyers are unaware of or do not understand the implications of these restrictions until their claims are denied. It is encouraging that the newer generation of policies generally have fewer restrictions and provide more flexible benefit options.

Perhaps most important, current long term care insurance policies are inaccessible to many older persons due to cost and underwriting restrictions. For most policies, the premium is determined by the age of the insured when he or she first buys the coverage. The monthly premium for a sixty-six year old is generally over $50; and for a seventy-six year old generally over $100. Few insurers will even sell to those over 80 years of age, and the premiums would be prohibitive if coverage were available. Additionally, those with potentially disabling medical problems are not eligible for most insurance plans. While this is necessary to maintain stable premiums, it leaves the disabled without any method to protect themselves from devastating long term care expenses.

Private long term care insurance confronts major demand problems for a variety of reasons. Most people seriously underestimate the risk of needing long term care, although recent estimates of the actual risk of needing nursing home care at some point in one's life range from 30% to 48%. Further, even those individuals who are aware of their statistical risk may deny that they themselves would ever be confronted with a disabling illness. Finally, many younger as well as older persons feel they cannot afford the premiums due to competing demands on their resources.

In the longer run, employer-based long term care insurance may be able to significantly increase affordability and availability. By enrolling workers in insurance plans at a relatively young age, protection against future long term care expenses can be provided for low costs. Few younger workers, however, recognize their potential risk of needing such services, and employers are justifiably concerned about creating new retiree health benefit liabilities when their availability to meet current obligations is in question. (Estimates of employers' unfunded accrued liability for retiree health benefits range from $98 billion in 1983 to several times that amount.) Clearly, substantial education of both workers and employers would be necessary before employer-based coverage could become a meaningful part of the solution. And even if these obstacles can be overcome, there will be those who are uninsurable or unable to afford coverage who will be left out of the private insurance system and dependent on Medicaid for protection.

AARP's Nursing Home and Home Care Insurance Plan

Along with other groups, AARP is working to overcome the obstacles to developing viable long term care insurance policies. In conjunction with the Prudential Insurance Company of America, AARP has test marketed a policy to its eligible members in certain states, and will begin offering it to most of its eligible members within the next month. We are doing so because private insurance helps to meet a real need of older persons, in the absence of better government protection. We also believe that we can have a positive impact on the market in terms of offering more flexible benefit options with fewer restrictions. Such a "prototype" policy may also be helpful in the later development of a public benefit, just as Blue Cross insurance served as a prototype for the Medicare benefit in 1965.

In late 1984, AARP initiated a survey research effort to elicit our members' views about the development of private insurance products to meet their long term care needs. We found that, despite many misperceptions about public program coverage for these expenses, the majority of our members wanted the Association to proceed with the development of products to help pay for long term (i.e. custodial or personal) care needs in the event of the onset of any disabling and/or chronic condition.

Based upon the survey findings, AARP began to work with Prudential and our independent consulting actuaries on the development of an AARP-sponsored, private long term care insurance plan. The product was test marketed in late 1985 and again in late 1986. Through these two tests, over 9,000 AARP members purchased coverage. The success of these tests has encouraged us to offer the program to our members nationwide later this summer.

A survey of buyers and non-buyers conducted following the last test indicates there were two primary reasons for purchasing the plan. The first related to the need for security and protection. Members wanted to take precautionary measures to protect themselves and their families from the potential financial devastation that future long term care needs could impose. Not surprisingly, buyers were more likely to have a relative or friend who had needed long term care than were non-buyers. Surprisingly, however, they were more likely to describe their health status as excellent. The other, clearly secondary reason for purchasing the AARP plan was the belief that it was the only coverage of this kind available.

Nearly eight out of ten buyers perceived the following three factors as most important in the decision to buy long term care insurance: 1) coverage of custodial care; 2) number of days of nursing home coverage, and 3) no prior institutionalization required for nursing home or home health care benefits.

A primary reason for not purchasing the plan was the lack of perceived need for this type of coverage, i.e. perceived sufficiency of current coverage under Medicare, employer-based group insurance and Medigap coverage. Many older persons, for example, have bought Medigap policies because they believed they would fill "all of the gaps" left by Medicare. When they learn that this is not true and that long term care is not covered, they are often confused and mistrustful.

Cost was also a significant reason cited for not purchasing the plan. This highlights a major shortcoming of reliance on private insurance to solve our long term care financing problems. Many lower income elderly cannot afford this insurance, even if they purchase at relatively younger ages (60-65) when premiums are lower. This underscores the desirability of financing long term care over a person's entire working life, rather than waiting until the retirement years. For those 75 and older, even the relatively well off may have difficulty affording the relatively substantial "entry-age" premium.

While AARP views these findings as important information about our members' understandng and preferences regarding long term care insurance, we want to emphasize that much more work needs to be done before we will have even a basic understanding of overall market demand and acceptance of long term care products. Many people still do not perceive that they are at risk of using long term care services. And because so few policies are available, general understanding of how this type of coverage actually works is undoubtedly low. Most important, little work has been done to test the preferences of workers and other younger individuals.

Proposals for Government Support for Private Insurance

A number of proposals for government support of the long term care market are being discussed. Most of the proposals involve the creation of tax incentives for consumers who buy long term care products and insurers which provide them. While it is important to investigate methods of making private insurance more widely available, we must be cautious in moving from discussion to policy. Just as this market is in its initial stages of development, so is our understanding about consumer demand and price sensitivity. Until we better understand these factors, as well as the ability of the private market to make coverage available and affordable, we should not commit ourselves to potentially costly tax policies and other incentives. Congress and the states need to carefully consider the potential efficacy of the incentives being proposed and their cost to the public purse.

Individual Medical Accounts

One of the more frequently mentioned ideas for promoting long term care insurance is the creation of the Individual Medical Account, or IMA. IMA's are tax-favored savings vehicles, similar to IRA's, which would permit individuals to make yearly contributions for their long term care needs. The interest in the account would accumulate tax free during the individual's lifetime and could be used either to purchase long term care insurance or to pay long term care expenses directly.

Relying upon individual savings rather than insurance to finance long term care makes little sense because the amount that one would need to save could be huge. We would not, for example, urge Americans to save against the risk of fire or other catastrophic risks. Even if individuals did attempt to save, their savings would provide no real assurance of protection since the price of care could easily outstrip the capacity to accumulate assets.

Other problems with the IMA approach are the same as those identified by Congress when it reconsidered the exemptions for IRA contributions last year. First, the tax incentives are not sufficiently attractive to encourage substantial participation by workers. A very low percentage of eligible individuals, around 16% in 1985, used the IRA deduction. Since IMA's would be for only a limited purpose, participation rates would probably be much lower. More important, like the IRA, it is likely that the IMA would be used mostly by the wealthy. Since these individuals are most able to afford existing long term care policies, it makes little sense for the government to subsidize their purchase.

Exempting Interest on Long Term Care Insurance Reserves from Taxation

Another method of potentially reducing the cost of long term care insurance products is to permit the interest on reserves for these policies to accumulate tax-free. This treatment is accorded to life insurance, but its application to existing long term care insurance is unclear. Many argue that long term care insurance should receive the same tax treatment as life insurance because, like life insurance, an integral part of long term care insurance products is the accumulation of funds over time to pay for benefits. Long term care insurance also fulfills an asset and income protection function similar to life insurance.

This approach deserves consideration. Especially if long term care insurance products can be developed that are attractive to younger workers and their employers, the long tax-free accumulation of interest could substantially reduce the premiums for coverage.

Tax Credits

Granting a tax credit to purchasers of long term care insurance is an incentive that has been considered in several states. Tax credits, which provide a direct and tangible benefit to purchasers, can potentially serve as an incentive to purchase coverage. It is not clear, however, how large the credit would need to be to encourage persons to purchase coverage who would not do so in its absence.

To make use of tax credits, one must file an income tax return. Because of changes due to the tax reform package, the majority of persons over age 65 are no longer required to file an income tax return. Therefore, many of the potential purchasers of long-term care insurance will not be able to take advantage of the incentive. An incentive program with broader applicability would probably be more effective and equitable.

Pension Fund Proposals

Most recently, proposals have been developed that would direct accumulated pension funds toward the purchase of long term care insurance. One proposal, which has been discussed by the Task Force on Long Term Care Health Care Policies, created pursuant to P.L. 99-272 would be to permit workers to transfer tax-free some of their vested pension funds for the purchase of long term care insurance. Yet other proposals include permitting employers to use "overfunded" pension plan assets to prefund retiree health benefits, including long term care.

These ideas are innovative, but they raise as many questions as they provide answers. Such proposals would represent a radical departure from current pension law and practice and could potentially endanger the funding of private pension plans. Pensions benefits are promises of future security, and we should be very slow to make changes in this system until we understand the full implications. What problems would such changes create for qualified plan funding? Would the promised insurance benefits be guaranteed to the same extent as pension income? Do the assets of "overfunded" pension plans belong to workers, to employers, or to both? These are just some of the questions that must be answered before these types of approaches should be attempted.

Further investigation and study of appropriate incentives for the long term care insurance market are necessary. We must begin, however, by learning more about why people choose to buy or not to buy these products. Incentives should be created to promote affordability and increased availability, not merely to subsidize those who already would purchase coverage.

The Need for a Strong Public Role in Long Term Care Financing

While private long term care insurance is a viable and attractive option for some Americans, it will by no means be a panacea to the long term care financing problem. It is essential for the government to play a much stronger role in financing long term care, and it is essential that this not lead to a "second class" system of care for the very old and the uninsurable -- precisely those individuals most likely to need long term care and least able to afford private coverage.

It is sometimes argued that long term care should be the responsibility of the private sector, not government. This argument ignores the fact that our nation has had a long and successful tradition of providing protection through social insurance against risks that threaten the basic security of Americans. Social Security, for example, has proved effective in providing basic protection against the risk of lost earnings due to retirement, disability, and death. Medicare has made major strides in protecting acutely ill older people from unmanageable health care expenses. And Medicare is able to return about $.98 in benefits for every $1 of financing, a loss ratio which private insurance could never hope to achieve.

The very nature of long term care also lends itself to a social insurance approach based on shared risk. If spread across people's working lives, comprehensive long term care coverage is certainly affordable. Moreover, these funds for insurance would come from shifting the burden away from the few who must now bear the brunt of the load to a broader population.

AARP believes that universal protection against the catastrophic risk of long term care is needed to provide a true "safety net" for Americans. Such a program, of course, must be designed to work in tandem with private sector approaches, just as our nation's private pension system complements our public pension system.

The Association wants to work with Congress to find realistic solutions to the long term care financing problem, and we are studying various mechanisms wich could be used to fund an expanded public program. These include Medicare premiums, estate taxes, premiums linked to the income tax structure, and payroll taxes. In evaluating various possibilities, we are guided by several general assumptions:

- The burden of paying for long term care should be shared between the retired and the working-age populations;
- Any new federal commitment to funding long term care should be fully funded; we do not want to add to the federal deficit;
- Mechanisms will need to be established to keep providers' costs at reasonable levels and to control utilization;
- Institutional and policy reforms must accompany any major financing change.

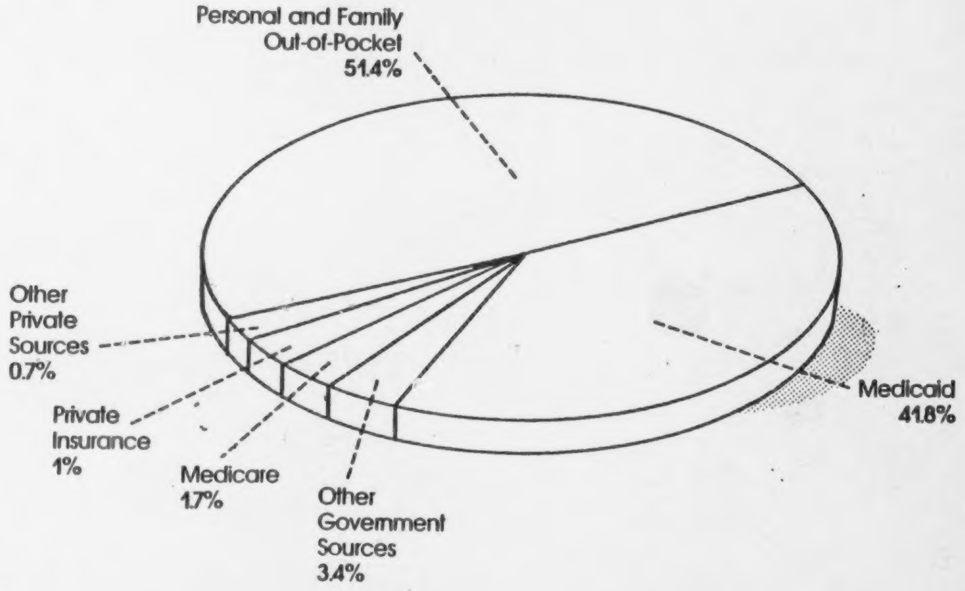
Conclusion

Because the greatest fears of older Americans are of becoming a burden on their families or being forced to enter a nursing home and spend their lifetime savings, there is no more important issue for AARP than the reform of our nation's long term care policies. We are pleased to offer our resources and assistance in finding solutions to what we believe will be one of the most pressing social issues of the late 1980's and early 1990's.

FIGURE 1

NURSING HOME COSTS
BY SOURCE OF PAYMENT, 1985

(A TOTAL OF $35.2 BILLION)



Source: Health Care Financing Administration, Office of the Actuary

Senator **Mitchell**. We will now have questions in accordance with the committee rules. The questions will be asked by Senators in the order in which they appeared. We have a five-minute limit for each round, and we will continue as long as any Senator has questions.

I will begin by briefly noting, all three of you, that as I said in my opening statement, we face two separate but related challenges in financing long-term care. First is to replace the current inequitable system that relies almost exclusively on out-of-pocket payments and Medicaid for the present group of elderly. The second is to devise a system of financing that takes into account the very significant decrease between now and a half-century from now, in the year 2020 and beyond, in the ratio of those employed to those who are retired.

As we all know, this problem will affect basic Social Security financing, including existing Medicare Programs. So, I ask you and subsequent witnesses to consider your answers to my questions in the light of both of those problems.

My first question is: Since at the present time the elderly and their families pay over half the costs of long-term care services themselves, is it reasonable to expect them to maintain that level of contribution in the aggregate, perhaps through public or private insurance premiums, rather than through out-of-pocket payments by individuals? I will begin with you, Dr. Wiener.

Dr. **Wiener**. The research that we have done at The Brookings Institution suggests that there are no magic bullets out there that will radically reduce the total amount of money that we spend on long-term care. As you noted in your opening statement, the long-range demographics are virtually unstoppable; and we will be spending a lot more on long-term care in the future. In fact, just by 2020, in constant dollars, we project that long-term care expenditures will triple. So, it seems to me that, especially given the projected increase in income by the elderly, that we as a society will have to pay more for it.

I think the key is to try to create some kind of insurance mechanism so that we pool the risks and the burden on any one individual is reduced.

Senator **Mitchell**. Mr. Libassi.

Mr. **Libassi**. Mr. Chairman, we would support and recognize the important role the Medicaid system plays in meeting nursing home costs and long-term care costs; and we would not in any way suggest that there are major deficiencies in that system.

The problem is that the few individuals who do go into nursing homes are financially unprepared. As Dr. Wiener has suggested, you need to find a way to help the families meet their half of the cost. And while there are ways of using accumulated savings and pension plans, IRAs, and so on, those do not share the risk. We would, therefore, favor an increased use of risk sharing as a way of helping a larger number of families prepare for the contingency that they may have to go into a nursing home. But at the same time, I hope we would look at other strategies that would reduce the costs of nursing homes.

At the present time, the issue of incontinence, for instance, adds about $3.00 to $11.00 a day to the costs of nursing home care. If we were able to increase our research in this area, we may be able in fact to reduce 10 to 20 percent of the cost of nursing homes by dealing with the issue of incontinence.

So, I would hope that, as we are dealing with the issues of spreading the risks, we are also dealing with the issues of how we get the costs down.

Senator MITCHELL. Mr. Maxwell.

Mr. MAXWELL. I agree with both of our witnesses. I think that it is important to recognize that this country has been able to establish a tradition of providing protection through the social insurance system. And it seems to me that risk pooling and sharing of the expense amongst the entire continuum of the population is important. Medicare has made real strides in terms of taking care of the acute illness problems; and actually, the Medicare system returns 98 cents for every $1.00 of financing. I don't think we in the insurance business ever could achieve a ratio like that; but it is important to us, it seems, that we do have a buildup and that, as the cost is spread across people's working lives, it becomes less necessary for us to have these catastrophic experiences in later life.

Senator MITCHELL. I appreciate what you have all said. I want to observe, with respect, that none of you directly answered my question, so I will restate it; and then you can think about it and give me an answer when I get back in the next round. It is obvious what you are all saying, that you have a specified group of people, a minority of whom will experience a very large expense.

And our purpose is to devise a mechanism applying insurance principles which take that aggregate expense and spread the risk—the cost of it—among the larger group.

Now, my question is: Currently, the cost is a fixed level. Mr. Libassi's comments are very good about reducing the cost, but there will still be an aggregate cost. The elderly and their families are now paying about half that cost. They are doing it in the inequitable manner which we have all just described, and we want to devise a mechanism for redistributing that cost. But my question is: Should the elderly in the aggregate, even under the new system which more equitably spreads the risk, bear approximately half the cost as they are now doing, albeit in different form? You wouldn't have specific individuals paying very large amounts; you would reduce the risk—the cost—to those affected, and everyone else would pick up a share of the cost. That is my question. I am really trying to get at the question of who pays for this; and I will have a follow-up, but I will leave that now and go to Senator Durenberger.

Senator DURENBERGER. Thank you, Mr. Chairman. First by way of observation, as we said earlier, there isn't an easy answer; let me be more specific.

There is reference in one of these statements to Secretary Bowens' work on catastrophic health care that I participated in. As I recall, Pete Ostrander who was then President of AARP and I were the only two people who didn't sign the report; and one of the reasons was that, as pointed out in Dr. Wiener's statement, it ended up saying that we ought to rely almost totally on the private sector insurance markets to resolve these problems. And I just wanted to clarify that my failure to sign the report was for that reason, but also it was not because I don't have confidence in private insurance. I do have a lot of confidence in it; it just seems to me that the problem is much larger.

I also don't agree that those creating a new public program is going to solve the problem either because that has all the utilization problems, and we are looking for a mix in between. And to try to find that, I tend to try to redefine or just to define—not redefine—income security, and to define income security as a society in terms of earnings and investments and savings and insurance and a social insurance system, and then some kind of income maintenance system for those in our society that cannot be sustained in their needs by the rest of that system.

And so, as we walk our way through long-term care, it strikes me that we find elements of all of this that need reform. People aren't saving, and so you can't use the savings system. The insurance is in here every year being taxed and retaxed in some different way, so the signal is changed there. Medicaid is today paying about 75 percent of the program going into some form of long-term care or some other elderly. And while we are begging for help from women and children and the growing number of uninsured poor in America, that resource—that income maintenance resource—isn't there to be used; and to a degree, we are creating conflict in a class sense between the elderly who have these various specific needs and have earned the right and the poor or young who can't seem to get at it.

So, it strikes me that we have a lot of work to do in solving the long-term care problem; but the insurance industry is offering us some opportunities, and I think this year in the Federal Employees Health Benefit Plan, I had a choice of some long-term care insurance. But I don't know how to exercise that choice. And this is by way of a question, I guess, to all of you or maybe particularly to Mr. Libassi, you mentioned consumer protection and information as important.

But when I go back and I try to read what I was offered, I am not sure, so I didn't take it, you know; but I am in the category, I guess, that could take it because I am over 50 or whatever it was. But I didn't know how to relate it to other things that I was doing for that period of time.

I sat with my folks last weekend, who are 80 and 75; I keep talking about them because they are sort of my role models. They are trying to decide because they are getting to the age when they need to make some alternative shelter decisions; and you know, they are trying to decide because this kind of home says turn it all your assets and we will take care of you. Somebody else says, no, you don't have to do that; all you have to do is pay us a little rent.

Last year on the tax bill, we did some break here for retirement homes, and I wasn't sure what we were doing. So, my question really deals with where the insurance industry is today in terms of long-term care coverage.

What is it precisely that these products are offering us, and how should we look at those products, and how should we compare those products with other opportunities that we have? And are we in any way standing in the way of better consumer information? Mr. Libassi?

Mr. **Libassi**. Members of the next panel will be even more capable to respond to that in detail. The insurance products that are now developing are in their first, second, and perhaps third generation. The nature of long-term care insurance provided by the private market is evolving and evolving very rapidly, so that the policies that were on the market two and three years ago are quite different than the policies that are on the market today and that will be on the market in the next five years.

So, in a way, it is difficult to describe them; but let me just very briefly say that they initially covered nursing home costs on a per diem basis; they are increasingly now covering nursing home and home care.

They originally required prior hospitalization; increasingly, the policies are no longer requiring prior hospitalization as a basis for providing a nursing home or home care benefit. Some originally required that you must be in a nursing home before you are eligible for home care. Now, policies are not requiring prior institutionalization in a nursing home. So, the products are evolving.

One of the issues that the State Commission faced was to be sure that our Consumer Protection Department and our Insurance Department were providing information of choices and alternatives to the consumer that would help inform them of the service and financing options. And I realize when you move from just insurance to social HMOs and continuing care retirement communities, and the actuarial uncertainties with respect to some of the retirement communities, we are moving the elderly into a very precarious area.

I would say, Senator, that this issue now is very much a family issue, where parents—as you as the child—are beginning to try to struggle through how do we all work together to deal with this issue.

Senator MITCHELL. Thank you, Mr. Libassi. Senator Riegle.

Senator RIEGLE. Thank you, Mr. Chairman. I think it is very important that we emphasize and make as clear as possible the fact that in this country long-term nursing home health care is essentially unavailable to most people who cannot pay for it out of their own pockets.

There is great confusion about this. Many people believe Medicare covers long-term nursing home care. It does not; and only where a person's assets are exhausted is there some eligibility for government assistance through the Medicaid program. Private insurance plans, for the most part, do not cover long-term health care, although that is now an area that some private insurers are beginning to examine. (I want to get to AARP's program in a minute.)

Also, most Medigap policies, from what I have been told, do not in a serious way address the question of long-term nursing home care. And, because the profile of the aging population of the country is changing so dramatically, as I said earlier, it may be very hard even to do good actuarial cost estimates of what we might be looking at here.

So, the question that Senator Mitchell raises regarding the size of the pool and the costs which we want to try to redistribute becomes a very complex one. For example, can we do it with a series of pools across the country, or should we think in terms of some kind of an aggregate national pool? It might be government financed—either directly or through a tax credit—or financed by the private sector. These are difficult questions we would have to address.

So, there are a lot of ways to view this. I would be very interested in knowing, Mr. Maxwell, in regard to the plan that you have crafted and you have test-marketed, how many people have already subscribed and what you are finding. You say you are going national later this year with your plan. Tell us about your plan and the degree to which there is a private financing component and how the private insurance industry does or does not fit into this plan that you have developed.

Mr. MAXWELL. I think that I have to explain that AARP is a nonprofit organization, and it would be unfair to compare our loss ratio, which we set at 78 percent, with that of industry.

Senator RIEGLE. I see.

Mr. MAXWELL. Because the insurance industry could not possibly operate on that basis. We test piloted this in four States; the second wave, we went to perhaps six States. We had about 9,000 people buy the policy. We are seriously concerned with the attitude and the understanding on people's part that Medicare, as you say—they think it covers—and it doesn't. And I think the major thrust of our work on Secretary Bowen's task force is to educate the public as to the lack of coverage.

In our second wave, we eliminated the three-day waiting period—the three-day acute experience. That eliminates a lot of people with diseases that ultimately force them into a nursing home environment.

Senator RIEGLE. Right.

Mr. MAXWELL. And so, we feel that we have a viable product. The big problem is we haven't any idea what the loss ratio is going to be. We have sought to determine what the cost should be to the public for the policy. It is a graduated policy.

Senator RIEGLE. Tell us how you did price it. How is it being priced? What does it cost a person who wants to come into this program on a monthly basis to have this insurance protection?

Mr. MAXWELL. I don't have my schedule with me, but if you start at age 50, it would be like $50.00 a month; and when you get to be aged 75, it is probably $300.00 to $400.00 a month. May I ask my staff?

Senator RIEGLE. Yes.

Mr. MAXWELL. All right. It is a lot cheaper than I thought it was. It starts out at $17.50 a month at 50, and it is $108.00 a month for people between 75 and 79.

Senator RIEGLE. Let me restate that so everybody has a chance to hear it. As I understand it, it starts at $17.50 a month at age 50 and graduates to $108.00.

Now, you stressed the fact that you are a nonprofit organization; and in effect, you are self-insuring. Is that what you are doing?

Mr. MAXWELL. In effect, we are not paying a local agent a commission. We are direct marketing it.

Senator RIEGLE. You are creating the insurance pool. You are going to collect the premiums; you manage the funds.

Mr. MAXWELL. Prudential is doing this for us.

Senator RIEGLE. You say you are tied in to a private company?

Mr. Maxwell. Oh, yes, absolutely.

Senator Riegle. With Prudential? So, in terms of the risk of financial loss, if your actuarial projections are wrong, does AARP take that on or does that get shouldered by Prudential?

Mr. Maxwell. No, that is shouldered by Prudential. It is strictly an insurance operation, and we simply provide the service to our membership because they can't find it other places.

Senator Riegle. Prudential has helped you structure this rate structure?

Mr. Maxwell. Oh, yes.

Senator Riegle. So, I take it they assume that you can go out and do this job, insofar as they are able to make those projections at those kinds of cost levels?

Mr. Maxwell. Yes.

Senator Riegle. That is interesting. So, you do have a private sector component that is right in the center of this.

Mr. Maxwell. That is true. I know what my problem was; I was thinking in terms of the family. Any time I think of long-term care insurance, I am going to insure my wife as well as myself. So, I was thinking in terms of almost double what Gary has cited.

Senator Riegle. Thank you.

Senator Mitchell. Senator Chafee.

Senator Chafee. Thank you, Mr. Chairman. I would like to ask this question to the panel as a whole, and I am interested in each of your answers. Each of you have come up with suggestions and what we might say are patchwork solutions to this problem; but do you really believe that this is a solution? My question is: Isn't it time that we look at the whole health care system in the United States and maybe start all over again? Now, that is a little radical; but when you end up with a program where you have 37 million people uninsured, you have working poor without proper coverage, you have inadequate prenatal care for mothers, you have this tie-in with Medicaid and AFDC; it just seems to me that whereas we might solve through some patchwork the immediate problem that is represented by the folks you are concerned with—namely the elderly—getting long-term care, are we just putting one more patch on a tire that really ought to be completely overhauled and a new approach?

What do you think of that, Dr. Wiener?

Dr. Wiener. That is a very tough question.

Senator Chafee. Well, I don't think it is so tough, but—[Laughter.]

Dr. Wiener. I think that we need to deal with those problems that you have identified, and I think personally that in order to do that, we will need a broader Government program than we have now to pick up the uninsured, the low income population and so on. It seems to me that the Government has a reasonable role in providing catastrophic coverage for everyone, and it should move in that direction.

The problem as always, going back to square one, is that there is a lot of water under the bridge; and it is hard to get major changes. So, I think Congress appropriately tries to make changes where it can and tries to make as strong a bandaid as it can get.

Senator Chafee. Mr. Libassi.

Mr. **Libassi**. Senator, the difficulty that we have just with the long-term care issue is indicative of the problems that I think we would face if we engaged in even larger-scale reform. It is difficult to predict and anticipate the consequences that will flow from a federal initiative in this area. Senator Mitchell earlier asked if we thought families should pay half of the costs. At the present time, the fact that families pay half the costs is probably not a bad system with public sectors paying the other half. And until we know how to adjust the system so that it will respond to additional resources, additional service, manpower, how people would respond if they have insurance—we do not know. Frequently, I am told that we misguess the reaction or responses of people and individuals as they go through the health care system.

My concern about taking on a larger reform is that, in just looking at this long-term care situation, I think there are so many imponderables that we need to move cautiously and very thoughtfully about in terms of trying to anticipate what will be the consequence of a Federal initiative of more money. More federal money into the long-term care system will not solve the long-term care problem; it may exacerbate it; it may distort the delivery system; it may force people into the most inefficient delivery mechanism, rather than the most efficient.

I think that has been the history of the last 20 years. So, when we start dealing with just the long-term care system, I would hope we would be very careful to try to measure the impact as we move along. And for that reason, I would be cautious about a larger-scale reform at this time.

Senator **Chafee**. Mr. Maxwell.

Mr. **Maxwell**. Senator, I am convinced that the United States provides the best medical care in the world, and I would hate to switch over to some system like socialized medicine that they have in England or in Sweden. And it seems to me that there are problems with our system, but it still provides great care to the public. Now, I realize that it may not be equally distributed amongst the public, but my real concern is that, if we can make the patches and can bring up a system that does meet the needs of the public, then we can look at how to make it an integrated system.

But boy, I hope we are not thinking about socialized medicine.

Senator **Chafee**. You know, the term "socialized medicine" gets all the alarm bells going off, and I am not so sure that that is necessarily an accurate characterization; but there certainly is an unequal distribution of the care in the system.

Mr. **Maxwell**. True.

Senator **Chafee**. And just the group that is here before us is representing—and particularly your organization—those who are suffering under it and suffering financially particularly in their families; but there is another whole group, as you noted in the catastrophic, the catastrophic we dealt with here is over 65. But there is another whole group out there who suffer from catastrophic, whether it is a child with cerebral palsy or whatever it is that aren't considered.

I will have another question when we go around again. Thank you. Thank you, Mr. Chairman.

Senator **Mitchell**. Senator Bradley.

Senator **Bradley**. Thank you very much, Mr. Chairman. Dr. Wiener, in your study, you came out with an advocacy position of public and private mixed financing for long-term care. Is that correct?

Dr. **Wiener**. That is correct. I think we have to expand both public sector involvement and private sector involvement.

Senator **Bradley**. If we look at the history of Medicare or Medicaid, when the Congress was contemplating those programs, we grossly underestimated the total costs of these programs. My question to you is: How can you be certain, once you have an entitlement financed by a payroll tax, which you say would be 2.5 percent split between employer and employee, that you won't have a mushrooming of demand and a greatly underfinanced program and, therefore, a much higher payroll tax?

Dr. **Wiener**. Senator, that is always a possibility. In producing our estimates in which we come up with a 2.5 to 2.8 percent flat payroll tax, we assume a 20 percent increase in nursing home utilization and in home care utilization. I think on the home care side that the key to keeping the costs under control is try to target services to a relatively small number of people.

If you limit services to people with three or more deficiencies in activities of daily living——

Senator **Bradley**. Excuse me. Limited to what?

Dr. **Wiener**. People with more than three deficiencies in activities of daily living.

Senator **Bradley**. And what does that mean?

Dr. **Wiener**. That means problems with bathing, eating, transferring, going to the bathroom—things of that nature.

Senator **Bradley**. So, they would have to have problems with three of these activities?

Dr. **Wiener**. There are approximately six that are typically measured. At any rate, if you limit it to that group of people, which is relatively disabled, you have significantly reduced the pool of people eligible for services and weeded out the more marginally disabled people.

We have estimated that you could cover that group of people for about what we currently pay for the Medicare home health benefit now, maybe 50 percent more than that. So, it seems to me that that is the strategy you would take on that end. And on the nursing home side, I think it is a mistake to think that people would jump into nursing homes if this kind of more public insurance were available.

I think all the evidence indicates that the elderly and their families desperately want to stay out of nursing homes and will go to very large lengths to do that. A 20 percent increase in utilization, in our estimates, I think is a fairly substantial one; but you can build into the estimate a higher increase in utilization if you like, but I think we are basically talking about something that would be between 2.5 and 3.2 percent payroll tax, which you could further reduce through premiums for the elderly, taxing inheritance, a variety of other things.

Senator **Bradley**. And you feel confident that you can identify the market? You feel confident that you can identify those elderly who are impaired in three of the six criteria?

Dr. Wiener. I think you could do that.

Senator Bradley. Do you agree with that, Mr. Libassi?

Mr. Libassi. I think theoretically that is possible, but that would require a case management system which does not exist in our country today. We have examples of case management which are developing, but in order to administer that kind of a program on a national basis would require a national case management system. Presently we do not have enough people trained in case management, and we do not have the people located in the right places to carry out that assessment. And I might just add that, aside from the expected increase in demand resulting from the system, in Connecticut we expect in the next 10 years to need 42 percent more nursing home beds. We expect to need 50 percent more home care services, simply by virtue of the growth of our population.

So, if you put a public financing system into Connecticut, you would not experience a 20 percent growth. Just to meet our current population growth, we would need even more. You need staffing; you need case management; you need facilities; you need a lot in order to sustain that system and maintain control.

Senator Bradley. My time is about up. So, Mr. Libassi, let me ask you this. In the private sector, would you be supportive of home equity conversions, where you use your home as a basis to pay for the premiums and the insurance that would then be paid back upon death through the sale of the home?

Mr. Libassi. Yes, Senator. There are some $750 billion in assets in value of homes now held by the elderly. Many poor elderly own their own homes. It is a partial solution to the financing issue, not appropriate for everyone; and certainly, there are a lot of emotional and psychological resistances to it. But in Connecticut, we have a State agency that administers a home equity conversion program, and the governor has recently increased flexibility in that program to increase its utilization in connection with long-term care. We believe it is part of the answer.

Senator Bradley. Do you agree, Dr. Wiener?

Dr. Wiener. I believe it is part of the answer, but I guess the work that we have done on home equity conversion suggests that it is difficult to generate enough cash income to meet the needs of people for long-term care, especially if they go into a nursing home. I am a fan of home equity conversion, but I think its role is more in general income supplementation for low income elderly than as a major financer of long-term care services.

Senator Mitchell. Thank you, Senator Bradley. Senator Rockefeller.

Senator Rockefeller. No questions, Mr. Chairman. I do have a statement to enter in the record, if I may.

Senator Bradley. Who pays the interest?

Dr. Wiener. The interest in home equity conversion?

Senator Bradley. Yes.

Dr. Wiener. The individual pays the interest from the proceeds from the sale of the home.

Senator Mitchell. Mr. Maxwell, you used the phrase "socialized medicine" twice in response to Senator Chafee's question. Most people generally understand socialization of anything to mean government involvement. You don't regard Medicare as socialized medicine, do you?

Mr. MAXWELL. No, sir. [Laughter.]

Senator MITCHELL. You don't regard Medicaid as socialized medicine?

Mr. MAXWELL. No, sir. I consider socialized medicine when the government says you can't do heart surgery on someone over 50 years old, as they do in England. There is something wrong with a system like that.

Senator MITCHELL. I have to agree with you, but I hardly think that the test of whether a program may be defined as socialized medicine is a mandate as to a certain type of operation at a certain age.

Mr. MAXWELL. It is one of the signals.

Senator MITCHELL. Medicare you think is a good program?

Mr. MAXWELL. Yes, sir.

Senator MITCHELL. All right. That is the one point I wanted to get to. I would like to ask you if you would respond now to my earlier question, which I will restate again.

Mr. MAXWELL. All right.

Senator MITCHELL. The elderly and their families are now paying in the aggregate about half the cost of long-term care. We are seeking a mechanism by which we distribute the cost more equitably to relieve that minority of the group who will incur expenses far beyond their means, to redistribute that cost among the entire group; but the cost will, of course, remain. And my question is: In devising a mechanism for financing, is it reasonable and fair to expect the elderly to continue to bear—the elderly and their families to bear—approximately half the burden, should that be increased or should it be decreased? Dr. Wiener?

Dr. WIENER. I think there is no question that the elderly will have to continue to pay a substantial part of the costs for long-term care; but I think half will probably be too large. If you consider that the current long-term care expenditures both for nursing home and home care services are about $1,200 for every elderly individual in the country, you take half of that, that is $600.00. That is a substantial amount for every elderly individual, and if you start cutting away from that by excluding low income individuals. If you project it out into the future when there are many more elderly come 2040, then total expenditures will probably be on the order of $2,400.00 or more contact 1987 dollars for every elderly individual. I think that is simply going to be too much to get out of the elderly population.

So, I think we need to spread the costs more broadly, but I think the fundamental principle needs to be for people—especially the baby boom population—to try to pay for its own long-term care through some kind of prefunding mechanism. I am a little more optimistic about prefunding public programs than you are, Mr. Chairman, because I don't really think there is any other alternative. If we do not have a prefunded base to draw from, then, we will have to impose a very significant burden on that working population in 2040.

Senator MITCHELL. So, your answer is that the proportion of the cost being borne by the elderly and their families should be decreased below the current level of approximately 50 percent?

Dr. WIENER. Yes, it is.

Senator MITCHELL. All right.

Dr. WIENER. I think the experience that the Senate has had as well, trying to raise $5 to $7 billion for the current catastrophic bill illustrates the limits of getting that money solely out of the elderly population.

Senator MITCHELL. Mr. Libassi, should that aggregate level be approximately the same, higher, or lower?

Mr. LIBASSI. I would recommend that it remain approximately the same at the present time. I think it is important that we not diminish the sense of personal and family responsibility for our relatives, for our parents. Increasing the public share and decreasing the private share, I think, is adverse to the natural instincts of trying to care for one's family members. I also think that we want to preserve choices in the medical system. Maintaining choices also it is a way of keeping the system functioning as efficiently as possible. You don't want a program which eliminates choices and options.

Also Mr. Chairman, this may be an excellent moment to pause and reflect on the consequences of expanding public funds for long term care at this time. I really do not believe we have the longitudinal data that would give us any confidence about predicting the consequences of increased public spending. Connecticut has eight years of longitudinal data on health care, but I cannot tell you today how long elderly in Connecticut stay in a nursing home. I cannot tell you how long they use private resources. I cannot tell you how much they contribute to their own support.

So, while we have a wealth of data in Connecticut, it is not in a usable form; and I don't believe we have it on a national level either. I would propose caution, reflection, and pause for a moment until we learn more about what is going on now and what we can expect will happen when public funds are increased.

Senator MITCHELL. Mr. Maxwell, can you just briefly tell me whether you think the level of contribution by the elderly and their families——

Mr. MAXWELL. We think it should be lower.

Senator MITCHELL. You think it should be lower?

Mr. MAXWELL. Yes. The basic principle of insurance is that a certain percentage of people will experience a catastrophe. You insure your home not expecting that it will ever burn down. Everybody insures their home, and the few that do burn down are supported in their catastrophe by the—you might call it—assessment against the general population. We feel that, at present, people who are experiencing the catastrophe are paying for it entirely.

If we have a social insurance program where the people who may never have to use it are making a contribution to the overall expense, it will reduce the expense for everyone and will take care of the catastrophic experience.

Senator MITCHELL. But you see, Mr. Maxwell, there were two ways of looking at both of the groups. You could regard the entire group as the population as a whole and the group to receive benefits as all elderly; or you can regard the larger group as all elderly and the group to receive benefits as those members of the elderly who will incur high long-term care expense. I gather yours is a combination of the two.

You would regard the larger group as the entire population, and the beneficiaries to be those elderly who experience high long-term care costs.

Does any other Senator have questions of this panel? Senator Chafee?

Senator CHAFEE. Thank you, Mr. Chairman. Mr. Libassi, in your comments you talked about better community-based alternatives. Is there not a tilt in the present system away from community-based alternatives, namely living at home?

Mr. LIBASSI. The present system actually encourages institutionalization in nursing homes, which I believe is not the most efficient approach to this problem. I do believe that we need to provide more care in the home, but also in the community, for instance, adult day care.

The governor of Connecticut has recently recommended that adult day care in Connecticut become a Medicaid-reimbursed service. Adult day care enables the family to have their elderly relative in a safe environment for the day while they go to work. They come home at night, they pick up their elderly relative from the adult day care program, and bring them home.

Senator CHAFEE. That is a Medicaid waiver, I presume?

Mr. LIBASSI. Yes, it would be a Medicaid-waived program. Connecticut will be able to cover adult day care through a Medicaid waiver. We also are doing more prescreening of Medicaid patients about to go into nursing homes to see if they can be diverted to their home and community-based care.

Senator CHAFEE. Let me ask Mr. Maxwell a question. Has any thorough study been done on preventative measures that would reduce the need of the elderly for nursing home care? And have they met with some success?

Mr. MAXWELL. Senator, I can't give you the detail, but may we furnish you with what we have done on this?

Senator CHAFEE. Yes.

[The prepared information follows:]

AARP

July 23, 1987

I suggest inserting
the circled material
on page 50.
Mary Jo Gibson

Senator John H. Chafee
567 Senate Dirksen Office Building
Washington, D.C. 20510

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Dear Senator Chafee:

I am writing in response to a question you posed to me during the hearing on long term care financing held June 12 before the Health Subcommittee of the Senate Finance Committee. You asked if any thorough study has been done on preventive measures that would reduce the need of the elderly for nursing home care. I replied that I would check on this and furnish you with details at a later date.

We are not aware of any study which has directly linked preventive health measures with reductions in the use of nursing homes. A growing body of research, however, indicates that many of the leading causes of disability and death, such as heart disease, stroke, cancer and accidents (such as hip fractures) are closely linked to lifestyle habits, such as smoking, improper diet, lack of exercise, and poor safety habits. In addition, many of the leading chronic conditions afflicting older adults, including arthritis, hypertension, and hearing and visual loss, can respond positively to exercise, healthy diets, and early preventive care. ~~For your information, I have enclosed several recent articles summarizing some of the research evidence on the impact of health promotion programs for the elderly in reducing health risks~~. Since many nursing home residents are afflicted with these chronic disabling conditions, we believe it is very plausible that health promotion measures may decrease the need for nursing home care in the future.

As part of its Health Advocacy Program, the American Association of Retired Persons is sponsoring a "Staying Healthy After Fifty" program aimed at enabling older Americans to maintain the capacity for independent living. ~~(Examples of educational materials from this program are enclosed.)~~ In addition, we are actively participating in and supporting the "Healthy Older People" program, a national public education campaign administered by the Office of Disease Prevention and

Health Promotion of the U.S. Public Health Service.

I thank you for the opportunity to respond to your question, which is an important one. Clearly, our nation must not only do everything it can to improve access to high quality long term care services in both community and institutional settings, but to prevent the need for long term care in the first place.

I hope that the enclosed information proves useful to you. If you should have further questions concerning this or any other matter, please do not hesitate to contact me.

Sincerely,

Robert B. Maxwell
Vice President

SK:mkc

Enclosures

Senator **Chafee**. I suspect that there are a lot of preventative measures that might be possible.

Mr. **Maxwell**. And we are encouraging that through programs for what we call "healthy living."

Senator **Chafee**. I would wonder if the results aren't rather astonishing. Have you got any information on that, Mr. Libassi?

Mr. **Libassi**. A physical exercise program which is being encouraged, as a matter of fact by AARP, is a very positive move to avoiding the physical deterioration of the elderly, which can be avoided by continued physical exercise and activity. Just that alone would be an important health promotion and disease prevention strategy—just straight exercise. Of course, stopping smoking at any time is a health benefit, regardless of age. Clearly, there are some very real disease prevention and health promotion strategies which we ought to pursue.

The idea that health promotion is only for those who can jog down the mall at lunchtime is, I think, a great disservice to our elderly. Physical exercise and health promotion ought to be right up to your very last day.

Senator **Chafee**. Is there any information on the health—mental health, if you would—and overall improvement of condition on those who attend these meals in a congregate setting?

Mr. **Libassi**. I do not have any data, and I would like to join with Mr. Maxwell in searching and providing it. Let me make just two comments. I believe we ought to take another look at continued employment of the elderly as a very important health promotion strategy. Continued employment beyond 60 and 62 years old is not unreasonable. I think not mandating it, but affording opportunities for people who want to keep working in order to remain mentally active, would be very positive. I think that physical exercise, social activities, activities with meals, family members, trips, things to look forward to, a suprise birthday party—all of those things are very important to keeping our elderly active, healthy, and to reducing the need for long-term care.

Senator **Chafee**. As you know, we have removed the limitation on retirement age on the federal level, anyway; and the discouraging part is that the overwhelming majority of Americans stampede toward the door when they reach age 65 or 62. So, I think you are right; but if voting by your feet is any indication, I would say the electorate is for early retirement.

Mr. **Libassi**. Senator, I might just add that increasing experience has shown that, to the extent the private employers are willing and able to provide part-time employment and flexible work arrangements, you do find retirees very interested in coming back to work. At my own company in Hartford, we have over 250 retirees every day working in our company who come back to work on some part-time schedule, either full time for six months or part time throughout the year. So, there is an interest on the part of elderly in part-time employment, and I would hope the private sector would respond with more employment opportunities for retirees.

Senator **Chafee**. I very strongly believe that there is a lot that can be done on the preventative side here, as you both have indicated. And I hope as we move along that that won't be overlooked. The whole tone of the Congress of the United States is toward taking care of people when they are sick rather than trying to keep people well.

Mr. LIBASSI. Yes.

Senator MITCHELL. Senator Bradley?

Senator BRADLEY. Thank you, Mr. Chairman. Let me just echo and support what Senator Chafee said about preventive care. Mr. Libassi, you indicated that you would go slowly now in terms of a public program expansion for long-term care because there wasn't adequate data. I am not sure I got all of the data you said that was really important to get. You said length of time in nursing home?

Mr. LIBASSI. Yes, Senator. The problem is that—we do not have adequate information on how long people stay in nursing homes. We also lack other important information.

Senator BRADLEY. What are those again? Could you list them for us?

Mr. LIBASSI. Yes. Service delivery, the extent to which services are used in the home; the issue of how rapidly people who are in nursing homes spend down their private assets and go onto Medicaid would be another issue. I would like to submit for the record, if I may, a more appropriate listing of those data collection needs.

But it is service utilization, both in the home and in nursing homes, and it is the financing issues that we would consider.

Senator BRADLEY. Now, why don't we have that data? You said in Connecticut you have been working on the data side for eight years.

Mr. LIBASSI. No one thought it would be necessary to put that information together until now. What we have in Connecticut is the Health Department having certain data with respect to people in nursing homes; and we have the Medicaid Department having data on who is on Medicaid. Unfortunately, those two systems did not include Social Security numbers. So, we are going to have to do a match by name and address to try to match up who is in a nursing home, when did they go in, and then who went on Medicaid.

Senator BRADLEY. So, you are in the process of doing that now in Connecticut?

Mr. LIBASSI. Yes, we are. The Governor has directed that the two departments aggressively put that data together, so we will be able to tell you when the person went in a nursing home and how long they stayed there.

Senator BRADLEY. Right. So, you will be able to answer all these questions in Connecticut?

Mr. LIBASSI. Yes, for Connecticut; and whether that data is applicable to Florida or other states is unknown at this time.

Senator BRADLEY. Right. Over what period of time?

Mr. LIBASSI. We hope to complete that within nine months, Senator.

Senator BRADLEY. Within nine months?

Mr. LIBASSI. Yes.

Senator BRADLEY. Do you have any idea what the situation is nationally in terms of data?

Mr. LIBASSI. My only information is that the Connecticut data, being collected for eight years, is one of the most extensive, longitudinal collections of data that we have. Now, I do not know about the extent to which this exists for other states. I am not a statistician, and I don't want to get into that area; I am too ignorant on it, Senator.

But I don't believe that we have in other States eight years of data that we can look back on.

Senator **Bradley**. Thank you.

Senator **Mitchell**. Thank you, Senator Bradley. Thank you, gentlemen, for very interesting and informative testimony.

The next panel will include Charles Atkins, Commissioner of the Massachusetts Department of Public Welfare; Burton E. Burton, President of the Employee Benefit Division of the Aetna Life Insurance Company, Hartford, Connecticut, speaking on behalf of the Health Insurance Association of America; and Ms. Mary Nell Lehnhard, Vice President of Blue Cross and Blue Shield Association, Washington, D.C.

Good morning, Ms. Lehnhard and gentlemen. As I indicated with the previous witnesses, your full statements will be placed in the record. We ask that you summarize orally your remarks in no more than five minutes; and when the yellow light comes on, you have got to start thinking about ending, and when the red light comes on, you have to end. So, we look forward to hearing from you. Mr. Atkins, welcome. Your reputation precedes you and it is a very high one. So, we look forward to your input.

STATEMENT OF CHARLES M. ATKINS, COMMISSIONER, MASSACHUSETTS DEPARTMENT OF PUBLIC WELFARE, AND CHAIRMAN OF THE HEALTH CARE COMMITTEE OF THE NATIONAL COUNCIL OF STATE HUMAN SERVICE ADMINISTRATORS

Mr. **Atkins**. Thank you, Mr. Chairman. I am Charles M. Atkins, Commissioner of the Massachusetts Department of Public Welfare. I am here today as the Chairman of the Health Care Committee of the National Council of State Human Service Administrators, comprised of welfare commissioners from across the country. The National Council of State Human Service Administrators is part of the American Public Welfare Association. Last November, the American Public Welfare Association issued a report entitled "Matter of Commitment," that called for major reform of public assistance programs for poor families and children.

As the day-to-day administrators of welfare programs across the country, we know first-hand what is wrong with the current welfare system, and we believe we have in "Matter of Commitment" presented specific recommendations as to how to fix the system. The report proposed new welfare initiatives to enhance self-sufficiency and help clients off the welfare rolls by expanding education and training programs that help clients obtain meaningful jobs and by providing adequate support for families in need while they are on welfare.

The report recommends the establishment in each State of a family living standard that eliminates the complex and overlapping eligibility rules of the several different benefit programs we currently have to administer. "Matter of Commitment," however, did not include specific recommendations on health care, but assigned that task to our Health Care Committee to work on this year.

Our committee is focusing on how to reform the health care system in order to compliment and strengthen the current proposals under consideration by Congress to overhaul the nation's welfare system. One of our chief concerns is to reduce the burden of long-term care expenditures and State Medicaid budgets so that we can address the unmet health care needs of poor families and children, pregnant women, and other underserved groups.

It is critical that we be able to do this in order to transform the Medicaid Program in this country into a health care delivery system which helps our clients make the transition from welfare to work. In Massachusetts, we have been operating an innovative welfare-to-work program for the past four years, called The Employment and Choices Training Program. ET, as it is known, assists over 600 clients a month to obtain full-time jobs paying almost $13,000 a year. ET has become known as a route out of poverty because that amount of money—$13,000 a year—is more than twice the cash welfare benefit of $5,600 a year we provide to the average family of three on welfare in Massachusetts and 30 percent above the Federal poverty line of $9,300 a year for that same family of three. That is the good news.

The bad news is that one-third of the jobs our ET graduates obtain do not have health insurance provided by their employers. Since the average family of three on welfare in Massachusetts and nationally consists of a 30-year-old mother and two children, when the children get sick the mother often has no choice but to quit her job and go back on welfare to obtain Medicaid for her children. As Commissioner of the Massachusetts Department of Public Welfare, I manage an agency with an annual budget of over $2 billion that has responsibility for cash assistance programs for the poor as well as for the Medicaid Program.

This year we will spend in Massachusetts more than $600 million on long-term care services, roughly half of our entire Medicaid budget and 20 percent more than we will spend on AFDC, our key cash benefit program for poor women and children.

And the national statistics are even worse. As you know, we spend over $45 billion nationally on Medicaid, more than half of which is spent on long-term care; and that amount is more than 50 percent greater than the $15 billion we spend on AFDC. I would like to highlight for you five principles of long-term care reform that our committee will consider in the coming months to present to all the welfare commissioners from across the country.

One, encouraging private and public programs that allow elders and their families to make choices based upon their needs and preferences among a wide array of social and medical services. Two, maintaining to the fullest possible extent the independence and self-sufficiency of elders while providing specific supportive services and assistance to families and other informal care-givers.

Three, giving States greater flexibility to design programs that promote and enhance community-based services as an alternative to institutional long-term care. For example, the cumbersome Federal rules on home and community-based waivers have slowed the development of community programs that combine a cost-effective continuum of social and medical services. Four, minimizing the perverse incentives stemming from Medicaid eligibility policies and encourage some middle class people to shelter assets and income while others impoverish themselves and their spouses because nursing home care is the only available option.

Five, encouraging the market for private long-term care insurance as a partial solution to financing community-based and institutional care. The key question is, of course, how to pay for all this.

Despite the current climate in Washington of fiscal restraint and a reduced role for the public sector in solving social problems, I implore you to make sure that broad-based, tax-supported, long-term care insurance, such as Medicare Part C be seriously considered by the Congress.

Ironically, as we have already talked about, we have a program of publicly supported long-term care financed by Federal and State taxes. That is the Medicaid Program.

Adding to the problem is the confusion you have already talked about caused by the widespread but inaccurate belief, particularly among the elderly, that Medicare or Medigap policies pay for long-term care. In fact, there are few alternatives for the elderly when it comes to paying for long-term care. They either pay out all of the costs out of their pockets or spend most of their income first to qualify for Medicaid funding. We believe that Government and the public would be better served by encouraging the development of private long-term care insurance and shared public and private funding arrangements.

Among the many public and private financing schemes under consideration, we want to take note of three. First, we welcome approaches that permit the public sector to participate in private insurance programs for low wage workers and other near poor individuals who cannot pay for or get access to long-term care insurance at middle age or later in life.

Second, we should explore the possibility of States buying into long-term care insurance for elders who cannot afford innovative programs, such as life care or community care retirement centers that otherwise may be available only for the well-to-do. And finally, third, we should encourage proposals that combine comprehensive prepaid health coverage with long-term care services so that elders receive continuity of care after episodes of acute illness.

We are especially interested in proposals such as yours, Mr. Chairman, that would encourage people to buy long-term care insurance as a precondition to obtaining Medicaid-funded services after benefit periods run out.

Thank you for inviting me to testify.

Senator MITCHELL. Thank you, Mr. Atkins. Mr. Burton, welcome. We look forward to hearing from you.

[The prepared written statement of Mr. Atkins follows:]

NATIONAL COUNCIL OF STATE
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TESTIMONY OF CHARLES M. ATKINS, COMMISSIONER
MASSACHUSETTS DEPARTMENT OF PUBLIC WELFARE
AND
CHAIRMAN, HEALTH CARE COMMITTEE
NATIONAL COUNCIL OF STATE HUMAN SERVICE ADMINISTRATORS
AMERICAN PUBLIC WELFARE ASSOCIATION

BEFORE THE

SUBCOMMITTEE ON HEALTH
COMMITTEE ON FINANCE, U.S. SENATE

HEARING ON FINANCING LONG-TERM CARE

JUNE 12, 1987

MR. CHAIRMAN, MEMBERS OF THE SUBCOMMITTEE, THANK YOU FOR INVITING ME TO TESTIFY TODAY. I AM CHARLES M. ATKINS, COMMISSIONER OF THE MASSACHUSETTS DEPARTMENT OF PUBLIC WELFARE. I AM HERE TODAY AS THE CHAIRMAN OF THE HEALTH CARE COMMITTEE OF THE NATIONAL COUNCIL OF STATE HUMAN SERVICE ADMINISTRATORS, COMPRISED OF WELFARE COMMISSIONERS FROM ACROSS THE COUNTRY. THE NATIONAL COUNCIL OF STATE HUMAN SERVICE ADMINISTRATORS IS PART OF THE AMERICAN PUBLIC WELFARE ASSOCIATION.

LINKING WELFARE REFORM AND HEALTH CARE REFORM

LAST NOVEMBER, THE AMERICAN PUBLIC WELFARE ASSOCIATION--COMPRISED OF BOTH STATE AND LOCAL PUBLIC WELFARE ADMINISTRATORS--ISSUED A REPORT ENTITLED MATTER OF COMMITMENT THAT CALLED FOR MAJOR REFORM OF PUBLIC ASSISTANCE PROGRAMS FOR POOR FAMILIES AND CHILDREN.

AS THE DAY-TO-DAY ADMINISTRATORS OF WELFARE PROGRAMS ACROSS THE COUNTRY, WE KNOW FIRST HAND WHAT'S WRONG WITH THE CURRENT WELFARE SYSTEM IN THIS COUNTRY, AND WE BELIEVE WE HAVE IN MATTER OF COMMITMENT PRESENTED SPECIFIC RECOMMENDATIONS AS TO HOW TO FIX THE SYSTEM.

THE REPORT PROPOSED NEW WELFARE INITIATIVES TO ENHANCE SELF-SUFFICIENCY AND HELP CLIENTS OFF THE WELFARE ROLLS:

- O BY EXPANDING EDUCATION AND TRAINING PROGRAMS THAT HELP CLIENTS OBTAIN MEANINGFUL JOBS; AND

- O BY PROVIDING ADEQUATE SUPPORT FOR FAMILIES IN NEED WHILE THEY ARE WELFARE. THE REPORT RECOMMENDS THE ESTABLISHMENT IN EACH STATE OF A FAMILY LIVING STANDARD THE ELIMINATES THE COMPLEX AND OVERLAPPING ELIGIBILITY RULES OF THE SEVERAL DIFFERENT BENEFIT PROGRAMS WE CURRENTLY HAVE TO ADMINISTER.

MATTER OF COMMITMENT AND THESE SUBSEQUENT WELFARE REFORM PROPOSALS DID NOT INCLUDE SPECIFIC RECOMMENDATIONS AS TO HOW TO REFORM THE HEALTH CARE SYSTEM, BUT ASSIGNED THAT TASK TO OUR HEALTH CARE COMMITTEE.

THE NATIONAL GOVERNORS ASSOCIATION ENDORSED MUCH OF OUR PROPOSAL AT THE MID-WINTER MEETING IN WASHINGTON LAST DECEMBER AND THE CONGRESS, AS YOU WELL KNOW, IS PRESENTLY WORKING ACTIVELY ON A NUMBER OF WELFARE REFORM BILLS.

A TASK FORCE OF OUR HEALTH CARE COMMITTEE HAS BEEN FORMED UNDER THE LEADERSHIP OF BARBARA MATULA, DIRECTOR OF NORTH CAROLINA'S MEDICAID PROGRAM.

THIS TASK FORCE IS NOW TURNING ITS ATTENTION TO REFORMS IN THE HEALTH CARE SYSTEM THAT WILL COMPLEMENT AND STRENGTHEN THE CURRENT PROPOSALS UNDER CONSIDERATION BY CONGRESS TO OVERHAUL THE NATION'S WELFARE SYSTEM. ONE OF OUR CHIEF CONCERNS IS TO REDUCE THE BURDEN OF LONG-TERM CARE EXPENDITURES ON STATE MEDICAID

BUDGETS SO THAT WE CAN ADDRESS THE UNMET HEALTH CARE NEEDS OF POOR FAMILIES AND CHILDREN, PREGNANT WOMEN AND OTHER UNDERSERVED GROUPS.

IT IS CRITICAL THAT WE BE ABLE TO DO THIS IN ORDER TO TRANSFORM THE MEDICAID PROGRAM IN THIS COUNTRY INTO A HEALTH CARE DELIVERY SYSTEM WHICH HELPS OUR CLIENTS MAKE THE TRANSITION FROM WELFARE TO WORK.

IN MASSACHUSETTS WE HAVE BEEN OPERATING AN INNOVATIVE WELFARE TO WORK PROGRAM FOR THE PAST FOUR YEARS CALLED THE EMPLOYMENT AND TRAINING CHOICES PROGRAM. ET, AS IT IS KNOWN, ASSISTS OVER 600 CLIENTS A MONTH OBTAIN FULL-TIME JOBS PAYING ALMOST $13,000 A YEAR. ET HAS BECOME KNOWN AS A ROUTE OUT OF POVERTY BECAUSE THAT AMOUNT OF MONEY--$13,000 A YEAR--IS MORE THAN TWICE THE CASH WELFARE BENEFIT OF $5600 A YEAR WE GIVE TO THE AVERAGE FAMILY OF THREE ON WELFARE IN MASSACHUSETTS AND 30% ABOVE THE FEDERAL POVERTY LINE OF $9300 A YEAR FOR THAT SAME FAMILY OF THREE. THAT'S THE GOOD NEWS.

THE BAD NEWS IS THAT ONE-THIRD OF THE JOBS OUR ET GRADUATES OBTAIN DO NOT HAVE HEALTH INSURANCE PROVIDED BY THEIR EMPLOYERS. SINCE THE AVERAGE FAMILY OF THREE ON WELFARE IN MASSACHUSETTS (AND NATIONALLY) CONSISTS OF A 30 YEAR OLD MOTHER AND TWO CHILDREN, WHEN THE CHILDREN GET SICK, THE MOTHER OFTEN HAS NO CHOICE BUT TO QUIT HER JOB AND GET BACK ON WELFARE TO OBTAIN MEDICAID FOR HER CHILDREN.

AS COMMISSIONER OF THE MASSACHUSETTS DEPARTMENT OF PUBLIC WELFARE, I MANAGE AN AGENCY WITH AN ANNUAL BUDGET OVER $2 BILLION THAT HAS RESPONSIBILITY FOR CASH ASSISTANCE PROGRAMS FOR THE POOR, AS WELL AS FOR THE MEDICAID PROGRAM. THIS YEAR WE WILL SPEND IN EXCESS OF $600 MILLION IN LONG-TERM CARE SERVICES--ROUGHLY HALF OF OUR ENTIRE MEDICAID BUDGET AND 20% MORE THAN WE WILL SPEND ON AFDC--OUR KEY CASH BENEFIT PROGRAM FOR POOR WOMEN AND CHILDREN.

YOU HAVE HEARD TESTIMONY PREVIOUSLY ON THE SOBERING DEMOGRAPHIC FACTS OF THE RAPID GROWTH OF THE ELDERLY POPULATION IN OUR SOCIETY. WHILE MORE RESOURCES ARE REQUIRED TO MEET THE NEEDS OF THIS GROUP, POOR WOMEN AND CHILDREN HAVE FACED A REAL DECLINE IN BENEFITS SINCE MANY STATES HAVE NOT ADJUSTED THEIR ELIGIBILITY LIMITS OR CASH PAYMENTS TO MEET INCREASES IN THE COST OF LIVING.

THIS DRASTIC IMBALANCE IN OUR NATIONAL METHOD OF FINANCING LONG-TERM CARE PRESENTS A VERY DILEMMA--WE EITHER MUST REDUCE STATE BUDGETS INTENDED FOR POOR CHILDREN AND FAMILIES, OR PLACE AN INTOLERABLE FINANCIAL BURDEN ON THE ELDERLY WHO REQUIRE LONG-TERM CARE.

NATIONWIDE, THE MEDICAID PROGRAM FINANCES NEARLY 50% OF THE $25 BILLION SPENT ANNUALLY ON NURSING HOMES FOR THE ELDERLY AND DISABLED. THE REST OF THESE ENORMOUS COSTS, WITH FEW EXCEPTIONS, ARE MET BY INDIVIDUALS WHO USE THESE SERVICES AND THEIR FAMILIES.

AT AN AVERAGE COST OF $25,000 A YEAR FOR NURSING HOME CARE, IF THESE ELDERLY ARE NOT POOR WHEN THEY ENTER A NURSING HOME, THEY UNFORTUNATELY SOON WILL BE.

WE IN GOVERNMENT MUST BE ABLE TO PROVIDE CARE TO OUR MOST VULNERABLE CITIZENS. BUT POOR WOMEN AND CHILDREN SHOULD NOT BE PUT IN THE POSITION OF HAVING TO COMPETE WITH THE ELDERLY FOR VITAL SERVICES THAT THEY MAY, IN FACT, DEPEND UPON FOR THEIR LIVES.

IN ORDER TO REFORM OUR WELFARE SYSTEM, WE MUST RECOGNIZE THAT THE MEDICAID PROGRAM HAS SERVED AS THE SAFETY NET FOR THE POOR AND THE NON-POOR ALIKE WHEN FACED WITH CHRONIC OR DISABLING CONDITIONS. UNFORTUNATELY, THIS HAS COME TO INCLUDE THE ELDERLY, MOST OF WHOM ARE UNAWARE THAT THEY WILL BE DEPENDENT NOT UPON MEDICARE--INTO WHICH THEY HAVE PAID DURING THEIR WORKING LIVES--BUT UPON MEDICAID.

WE NEED NEW FINANCING METHODS THAT WILL REMOVE LONG-TERM CARE EXPENDITURES FROM MEDICAID AND GIVE STATE AND LOCAL ADMINISTRATORS THE FLEXIBILITY TO PROVIDE COST-EFFECTIVE AND HIGH QUALITY HEALTH CARE TO ALL FAMILIES AND CHILDREN IN NEED.

LATER THIS YEAR, OUR HEALTH CARE COMMITTEE WILL PRODUCE A COMPANION PIECE TO THE MATTER OF COMMITMENT PAPER THAT WILL ADDRESS THESE ISSUES IN MORE DETAIL.

PUBLIC/PRIVATE COOPERATION: THE MASSACHUSETTS EXPERIENCE

BEFORE I HIGHLIGHT THE PRINCIPLES OF LONG-TERM CARE REFORM THAT OUR COMMITTEE WILL CONSIDER IN THE COMING MONTHS, I FIRST WANT TO TAKE A MOMENT TO DESCRIBE SOME OF OUR EXPERIENCES IN MASSACHUSETTS IN DESIGNING PROGRAMS THAT COMBINE PUBLIC AND PRIVATE SECTOR INITIATIVES.

OVER THE LAST FOUR YEARS, WE HAVE MOVED AGGRESSIVELY TO REFORM THE STATE'S APPROACH TO WELFARE. IN 1983, WE BEGAN THE ET PROGRAM, WHICH AS I MENTIONED PREVIOUSLY, ENABLES MORE THAN 600 WELFARE RECIPIENTS EACH MONTH TO OBTAIN FULL-TIME UNSUBSIDIZED JOBS, PRIMARILY IN THE PRIVATE SECTOR.

LAST YEAR WE BEGAN A PROGRAM CALLED HEALTH CHOICES, MODELED AFTER ET, WHICH IS DESIGNED TO PROVIDE WELFARE RECIPIENTS, INCLUDING THOSE WHO OBTAIN JOBS, WITH ACCESS TO DIFFERENT TYPES OF QUALITY, COST-EFFECTIVE MEDICAL CARE. HEALTH CHOICES IS ALSO DESIGNED TO BRIDGE THE TRANSITION FROM WELFARE TO WORK AND HELP CLIENTS OUT OF POVERTY AND TOWARDS SELF-SUFFICIENCY.

BOTH OF THESE PROGRAMS--ET CHOICES AND HEALTH CHOICES--SHARE FEATURES THAT ARE RELEVANT TO YOUR CONSIDERATION OF LONG-TERM CARE REFORM AS WE SEEK TO REDUCE OUR COUNTRY'S OVERWHELMING RELIANCE ON A SINGLE OPTION--NURSING HOME CARE--AND CREATE A MENU OF SERVICES THAT MEET THE DIVERSE NEEDS OF THE ELDERLY IN THE COMMUNITY AND OUR INSTITUTIONS.

FOUR ELEMENTS OF ET AND HEALTH CHOICES SUGGEST THE KIND OF PUBLIC AND PRIVATE SECTOR APPROACHES THAT COULD TRANSFORM OUR LONG-TERM CARE DELIVERY SYSTEM:

1. THEY EMPHASIZE CLIENT CHOICE...AND MATCHING SERVICES TO CLIENTS' NEED AND PREFERENCES, RATHER THAN FORCING CLIENTS TO ACCEPT WHAT'S AVAILABLE.

2. THEY COMBINE FLEXIBLE PUBLIC AND PRIVATE SECTOR INITIATIVES, INCLUDING PERFORMANCE-BASED CONTRACTS BETWEEN PUBLIC AGENCIES AND AMONG A DIVERSE GROUP OF PRIVATE PROVIDERS.

   THESE CONTRACTS EMPHASIZE OUTCOMES THAT MAKE A DIFFERENCE FOR OUR CLIENTS, SUCH AS GOOD PAYING JOBS WITH BENEFITS FOR WELFARE RECIPIENTS OR COST-EFFECTIVE, HIGH QUALITY HEALTH CARE FOR CHILDREN AND THEIR FAMILIES.

3. THEY USE AGGRESSIVE MARKETING AND OUTREACH TO RAISE AWARENESS OF AVAILABLE SERVICES AND TO TARGET CLIENTS FOR THE MOST APPROPRIATE MIX OF SERVICES.

4. THEY PROVIDE CASE MANAGEMENT AT BOTH THE FRONT END OF THE SYSTEM AND PERIODICALLY AS CLIENTS' NEEDS CHANGE. CASE MANAGEMENT PERMITS US TO MATCH THE RIGHT SERVICES TO CLIENTS AND HELPS TO INSURE THAT DIFFICULT-TO-SERVE GROUPS

GET A FAIR SHARE OF THE SERVICES WE BUY THROUGH CONTRACTS.

PRINCIPLES FOR LONG-TERM CARE REFORM

I WOULD LIKE TO HIGHLIGHT FOR YOU FIVE PRINCIPLES OF LONG-TERM CARE REFORM THAT OUR COMMITTEE WILL CONSIDER IN THE COMING MONTHS TO PRESENT TO ALL THE WELFARE COMMISSIONERS:

1. ENCOURGAGING PRIVATE AND PUBLIC PROGRAMS THAT ALLOW ELDERS AND THEIR FAMILIES TO MAKE CHOICES, BASED UPON THEIR NEEDS AND PREFERENCES AMONG A WIDE ARRAY OF SOCIAL AND MEDICAL SERVICES.

2. MAINTAINING TO THE FULLEST POSSIBLE EXTENT THE INDEPENDENCE AND SELF-SUFFICIENCY OF ELDERS WHILE PROVIDING SPECIFIC SUPPORTIVE SERVICES AND ASSISTANCE TO FAMILIES AND OTHER INFORMAL CAREGIVERS.

3. GIVING STATES GREATER FLEXIBILITY TO DESIGN PROGRAMS THAT PROMOTE AND ENHANCE COMMUNITY-BASED SERVICES AS AN ALTERNATIVE TO INSTITUTIONAL LONG-TERM CARE. FOR EXAMPLE, THE CUMBERSOME FEDERAL RULES ON HOME- AND COMMUNITY-BASED WAIVERS HAVE SLOWED THE DEVELOPMENT OF COMMUNITY PROGRAMS THAT COMBINE A CONTINUUM OF SOCIAL AND MEDICAL SERVICES.

4. MINIMIZING THE PERVERSE INCENTIVES STEMMING FROM MEDICAID ELIGIBILITY POLICIES THAT ENCOURAGE SOME MIDDLE CLASS PEOPLE TO SHELTER ASSETS AND INCOME, WHILE OTHER IMPOVERISH THEMSELVES AND THEIR SPOUSES BECAUSE NURSING HOME CARE IS THE ONLY AVAILABLE OPTION.

5. ENCOURGAGING THE MARKET FOR PRIVATE LONG-TERM CARE INSURANCE AS A PARTIAL SOLUTION TO FINANCING COMMUNITY-BASED AND INSTITUTIONAL CARE.

I KNOW THAT YOUR PARTICULAR INTEREST TODAY IS THE FINANCING OF LONG-TERM CARE. DESPITE THE CURRENT CLIMATE OF FISCAL RESTRAINT, AND A REDUCED ROLE FOR THE PUBLIC SECTOR INVOLVING SOCIAL PROBLEMS, BROAD-BASED, TAX-SUPPORTED LONG-TERM CARE INSURANCE--SUCH AS THE MEDICARE PART C PROPOSAL--MUST COME BEFORE THE CONGRESS.

IRONICALLY, WE ALREADY HAVE A PROGRAM OF PUBLICLY-SUPPORTED LONG-TERM CARE FINANCED BY FEDERAL AND STATE TAXES. AS I STATED AT THE OUTSET: IT'S CALLED MEDICAID.

ALTHOUGH IT SERVES POOR AND NON-POOR ALIKE, MEDICAID REMAINS A WELFARE ENTITLEMENT PROGRAM. THIS LEADS TO WIDESPREAD PUBLIC MISREPRESENTATION ABOUT "WELFARE BUDGETS OUT OF CONTROL" AND TO FREQUENT JOUSTING WITH LEGISLATURES OVER COVERING THE COSTS OF

HEALTH PROGRAMS FOR THE POOR AND INSTITUTIONAL LONG-TERM CARE FOR THE ELDERLY AND DISABLED.

ADDING TO THE CONFUSION IS THE WIDESPREAD BUT INACCURATE BELIEF AMONG THE ELDERLY THAT MEDICARE OR MEDI-GAP POLICIES PAY FOR LONG-TERM CARE. IN FACT, THERE ARE FEW ALTERNATIVES FOR THE ELDERLY WHEN IT COMES TO PAYING FOR LONG-TERM CARE THEY EITHER PAY ALL OF THE COST OUT OF THEIR POCKETS OR SPEND MOST OF THEIR INCOME FIRST TO QUALIFY FOR MEDICAID FUNDING.

THE REALITY IS THAT SOME ELDERLY WITH MEANS ARE ABLE TO SHIFT THEIR ASSETS TO CHILDREN OR FAMILY MEMBERS AND THEN QUALIFY FOR MEDICAID. OTHER ELDERS ARE FORCED TO DEPLETE THEIR SAVINGS OR OTHER ASSETS IN ORDER TO PAY NURSING HOME COSTS PRIOR TO MEDICAID ELIGIBILITY. THIS HAPHAZARD, AND SOMETIMES DRACONIAN, SYSTEM OF EITHER FRAUDULENT OR FORCED IMPOVERISHMENT IS NEITHER FAIR NOR EFFICIENT.

ENCOURGAGING PRIVATE SECTOR SOLUTIONS

WE BELIEVE THAT THE GOVERNMENT AND PUBLIC WOULD BE BETTER SERVED BY ENCOURAGING THE DEVELOPMENT OF PRIVATE LONG-TERM CARE INSURANCE AND SHARING PUBLIC AND PRIVATE SHARED FUNDING ARRANGEMENTS.

PREVIOUS TESTIMONY BEFORE YOUR COMMITTEE CITED RESEARCH SUGGESTING THAT PRIVATE LONG-TERM CARE INSURANCE WILL ONLY MARGINALLY

REDUCE MEDICAID EXPENDITURES OVER THE LONG RUN BECAUSE THE MINORITY OF ELDERS WHO CAN AFFORD THE PREMIUMS WOULD HAVE BEEN PRIVATE-PAY NURSING HOME RESIDENTS ANYWAY.

BUT THE INVESTMENT BY EMPLOYEES AND OTHER GROUPS NOW IN POOLED RISK PLANS IS STILL A WORTHWHILE OPTION. THE DEVELOPMENT OF GROUP PLANS IN PARTICULAR WILL SPREAD THE COSTS OF LONG-TERM CARE MORE EQUITABLY IN THE FUTURE AND WILL PERMIT US TO TARGET PUBLIC FUNDS TO ELDERS WITH FEWER RESOURCES.

REFORM MEASURES SHOULD ALSO INCLUDE A LESSENING OF OVERLY-RESTRICTIVE STATE REGULATORY RULES THAT ARE IMPEDING THE DEVELOPMENT OF PRIVATE LONG-TERM CARE INSURANCE PRODUCTS. AT THE SAME TIME, WE AGREE THAT THE FEDERAL AND STATE GOVERNMENTS HAVE A DUTY TO MONITOR THE QUALITY AND PERFORMANCE OF THESE PLANS. THESE PRODUCTS SHOULD BE SUFFICIENTLY COMPREHENSIVE TO OFFER HOME CARE AND OTHER COMMUNITY-BASED SERVICES.

AMONG THE MANY PRIVATE AND PUBLIC FINANCING SCHEMES UNDER CONSIDERATION, WE WANT TO TAKE NOTE OF THREE:

o FIRST, WE WELCOME APPROACHES THAT PERMIT THE PUBLIC SECTOR TO PARTICIPATE IN PRIVATE INSURANCE PROGRAMS FOR LOW WAGE WORKERS AND OTHER NEAR POOR INDIVIDUALS WHO CANNOT PAY FOR, OR GET ACCESS TO, LONG-TERM CARE INSURANCE AT MIDDLE AGE OR LATER IN LIFE.

- SECOND, WE SHOULD EXPLORE THE POSSIBILITY OF STATES "BUYING-IN LONG-TERM CARE INSURANCE FOR ELDERS WHO CANNOT AFFORD INNOVATIVE PROGRAMS SUCH AS COMMUNITY CARE RETIREMENT CENTERS THAT MIGHT OTHERWISE BE AVAILABLE ONLY TO THE WELL OFF.

- THIRD, WE SHOULD ENCOURAGE PROPOSALS THAT COMBINE COMPREHENSIVE PREPAID HEALTH COVERAGE WITH LONG-TERM CARE SERVICES SO THAT ELDERS RECEIVE CONTINUITY OF CARE AFTER EPISODES OF ACUTE ILLNESS.

WE ARE ESPECIALLY INTERESTED IN PROPOSALS, SUCH AS YOUR'S MR. CHAIRMAN, THAT WOULD ENCOURAGE PEOPLE TO BUY LONG-TERM CARE INSURANCE AS A PRECONDITION TO OBTAINING MEDICAID FUNDED SERVICES AFTER BENEFIT PERIODS RUN OUT.

MR. CHAIRMAN, I HAVE TOUCHED ON A FEW OF THE MAJOR TOPICS THAT WE LOOK FORWARD TO REVIEWING WITH YOUR COMMITTEE AND STAFF IN THE COMING MONTHS.

BUT THE UNDERLYING MESSAGE IN MY REMARKS IS THAT, FOR THE MOST PART, THE ELDERLY AND DISABLED, WITH THE SUPPORT OF THEIR FAMILIES AND FRIENDS, KNOW WHAT THEY NEED TO LIVE INDEPENDENTLY IN THE COMMUNITY, OR TO LIVE WITH DIGNITY IN A INSTITUTIONAL ENVIRONMENT WHEN NO OTHER OPTION IS APPROPRIATE.

WE SHOULD CONCENTRATE ON REMOVING BUREAUCRATIC AND REIMBURSEMENT BARRIERS THAT IMPEDE COORDINATION OF SOCIAL AND HEALTH SERVICES AT HOME, IN THE COMMUNITY, AND WITHIN NURSING HOMES AS WELL.

STATES SHOULD BE ABLE TO OFFER, TO THE FULLEST EXTENT POSSIBLE, THE SAME MENU OF OPTIONS TO THE POOR AND THE WELL-OFF SO THAT BENEFITS ARE BASED ON NEED AND NOT DEPRIVATION OR OTHER FACTORS THAT SEGREGATE ONE CLASS FROM ANOTHER.

FOUR YEARS AGO, WHEN WE EMBARKED ON WELFARE REFORM IN MASSACHUSETTS THROUGH OUR ET CHOICES PROGRAM, SKEPTICS TRIED TO ARGUE THAT WELFARE MOTHERS DID NOT WANT TO WORK. WE PROVED THESE CRITICS WRONG.

PREJUDICE AGAINST THE POOR AND RACISM REMAIN SERIOUS BARRIERS TO OPPORTUNITY FOR OUR RECIPIENTS. BUT YOUR COMMITTEE WILL HAVE TO TACKLE A DIFFERENT BIAS IN OUR SOCIETY: AGEISM AND THE NOTION THAT THE VERY OLD CANNOT LEAD USEFUL AND DIGNIFIED LIVES.

YOU HAVE HEARD AMPLE TESTIMONY TO THE CONTRARY IN RECENT MONTHS, AND WE ENCOURAGE YOUR EFFORTS TO STRUCTURE NEW BENEFITS AND PROGRAMS THAT EMPOWER THE ELDERLY TO OBTAIN HELP WHERE THEY WANT IT, AND WHEN THEY NEED IT, RATHER THAN SPENDING TOO MUCH MONEY FOR INSTITUTIONAL CARE THAT MIGHT HAVE BEEN AVOIDED OR POSTPONED.

FINALLY, WE WELCOME YOUR EFFORTS TO AFFIRM GOVERNMENT'S COMMITMENT TO LONG-TERM CARE BY ENCOURAGING NEW FINANCING MECHANISMS THAT COULD SLOW THE GROWTH OF THESE EXPENDITURES WITHIN MEDICAID BUDGETS AND PERMIT US TO BETTER SERVE THE HEALTH CARE NEEDS OF POOR FAMILIES AND CHILDREN.

I WOULD BE HAPPY TO ANSWER ANY QUESTIONS YOU MAY HAVE.

STATEMENT OF BURTON E. BURTON, PRESIDENT OF EMPLOYEE BENEFITS DIVISION, AETNA LIFE INSURANCE CO., HARTFORD, CT, ON BEHALF OF THE HEALTH INSURANCE ASSOCIATION OF AMERICA

Mr. BURTON. Thank you, Mr. Chairman. I am pleased to testify today on behalf of the Health Insurance Association of America and its 335 member companies. The insurance industry is justifiably proud of the role it has played in the evolution of the largest private insurance system in the world. Now, we are entering the next logical phase of this evolution: the improving of financial resources of the elderly makes insurance against the costs of long-term care both desirable and affordable, and it is time to begin folding long-term care into this country's extensive private insurance system.

Long-term care embodies most of the characteristics of the situation suited to insurance. There are, however, serious problems of adverse selection, moral hazard, and lack of data that our insurers are working to overcome.

Although there has been a small private market for long-term care insurance in this country for some time, widespread misunderstanding among the elderly about the extent of Medicare coverage coupled with other higher priority uses for their funds has limited its impact. Today, however, there is growing understanding of the need to prefund and to spread long-term care costs. As a result, in the past three years the number of insurers offering long-term care products, the number of individuals covered, and the variety of products being developed have all increased dramatically. About 70 insurance companies now offer individual long-term care policies, and there are currently about 423,000 policies in force. In addition, four large commercial carriers—Aetna, Metropolitan, Prudential, and Travelers—now offer a variety of group coverages and several others have announced plans to begin marketing group products.

Aetna is a good example of this trend. My company began offering an individually underwritten policy in October of 1985. Approximately 22,500 policies have been sold to date.

Last year we offered a group long-term care plan to our major group insurance clients. The first such plan, sponsored by the State of Alaska for its retirees, was effective last week. In just two months, we have signed up nearly 30 percent of the 7,500 eligible retirees, and including spouses, 3,100 people are now covered.

We are very pleased with these early results and expect to add other group contracts in the near future. Despite the vigorous insurance industry response, however, there are still several obstacles that inhibit full market development.

The first is the low level of consumer awareness about the risks and costs of long-term care, coupled with a widespread belief that Medicare or private Medigap insurance covers these costs. The need for better consumer education is a responsibility for both the private and the public sectors. And as a contribution to this effort, the Health Insurance Association will shortly publish a consumer guide to long-term care insurance. Secretary Bowen has written the foreword, and it has been endorsed by the American Association of Retired Persons.

The second obstacle we face in designing and pricing policies is a lack of data on utilization patterns and the costs of long-term care. It would be very helpful to have access to Federal and State data in a readily usable form.

We have made some progress in this direction already. The Department of Health and Human Services will make available several national data bases this year. The third obstacle is an uncertain regulatory and tax environment. While long-term care has most of the characteristics of an insurable event, much about the nature and extent of the risk will only become known after a period of years.

Accordingly, we need a regulatory environment which recognizes that this is a new market and that its products are somewhat fragile and can be damaged by rough treatment.

An ideal regulatory framework within which to develop long-term care products would be flexible and supportive, encouraging the necessary risk taking by insurers. The National Association of Insurance Commissioners model long-term care legislation has many of these characteristics. It is flexible enough to meet the range of demands in the marketplace and yet strong enough, we believe, to provide adequate consumer protection. It has been enacted in several States already with Health Insurance Association support and is actively being considered in others.

Like the regulatory environment, the Federal tax environment needs to be supportive if long-term care insurance is to accomplish its social potential. We are encouraged by the request from the Finance Committee to Treasury that it conduct a study of the treatment of long-term care insurance under the Tax Code. In order to expand long-term care, we believe the Federal Government perhaps first and foremost should clarify that the tax treatment of long-term care insurance reserves held by insurers and the investment earnings on them are deductible by insurers.

Similarly, the premiums paid, particularly contributions by employers, and the benefits received should be treated in a manner similar to that of medical premiums and benefits.

We have some other tax suggestions. They are included in our detailed statement. I must mention just one, and that is the attraction of including long-term care insurance within cafeteria plans.

Senator MITCHELL. The attraction of what?

Mr. BURTON. The great attractiveness of including long-term care insurance options within cafeteria plans so that employees can elect to spend the money in that direction.

Senator MITCHELL. Thank you very much, Mr. Burton. Ms. Lehnhard, welcome. We look forward to hearing from you.

[The prepared written statement of Mr. Burton follows:]

Statement

of the

Health Insurance Association of America

On

THE FINANCING OF LONG TERM CARE

Presented by

Burton E. Burton

President, Employee Benefits Division

Aetna Life and Casualty

Before the

Subcommittee on Health

Committee on Finance, United States Senate

June 12, 1987

I am Burton E. Burton, President of the Employee Benefits Division of Aetna Life and Casualty. Aetna is one of the leading insurance company providers of individual and group life and health insurance benefits, and pension and financial services. We have over 17,000 employer customers, who are pension or welfare benefit plan sponsors, and we insure or administer benefits for more than 15 million employees and dependents under group plans providing life and health insurance. In addition to these group plans, we have over 150,000 individual health policies.

I am pleased to testify today on behalf of the Health Insurance Association of America. The HIAA represents about 335 member insurance companies which write over 85 percent of the private health insurance available from commercial insurance companies in this country.

The insurance industry is justifiably proud of the role it has played in the evolution of the largest private insurance system in the world. Over 80 percent of American households own life insurance. More than 90 percent of the non-poor under age-65 population and over 80 percent of workers and their dependents have private health insurance coverage. And about 70 percent of workers in the "ERISA workforce" are covered by employer pension plans.

This situation didn't occur overnight. It evolved, mainly after World War II, as the nation's growth and productivity increased national income and allowed people to look beyond cash income to securing themselves against premature death, unexpected illness or disability, and the vicissitudes of retirement.

Now, we are entering the next logical phase of this evolution. The advances in both medical technology and general health that are increasing the lifespan of the elderly are also increasing the number of people who will require treatment for chronic illness. Simultaneously, rising income, particularly among the elderly, makes insurance against the costs of long term care both desirable and affordable. The time has come to begin folding long term care into this country's extensive private insurance system.

Our testimony will focus on four items:

- the character of long term care expenses and why they lend themselves to insurance coverage;
- the new long term care products which the insurance industry is rapidly developing;
- the challenges we face in attempting to meet the need for long term care insurance;
- the areas in which government action is required to advance the effort to provide widespread protection against the expenses of long term care.

Nature of the Problem

When we speak of "long term care," we are describing a wide range of medical and support services provided to individuals who have lost some or all capacity to function on their own due to a chronic illness or condition and who are expected to require these services for an extended period of time.

As this Subcommittee is aware, long term care is the major source of catastrophic illness expense paid for directly by the elderly today. On average, for those elderly with out-of-pocket health care expenses over $2,000 a year, 80 percent of these expenses are for nursing home care. With nursing home costs estimated to average $29,000 per year in 1987, such expenses can indeed represent a catastrophic financial drain.

Not everyone will need nursing home care, however. Somewhere between 25 and 40 percent of the elderly are likely to require nursing home care at some point in their lives. Of these, only about half will be institutionalized for more than 90 days. Long term care embodies many of the characteristics of a situation suited to insurance: a potentially very expensive event, difficult to predict for an individual, for which the frequency is sufficiently low that the cost per person, spread across a large group, is quite modest. There are, however, very serious problems of adverse selection, moral hazard and lack of data facing insurers.

Over the last three decades, both the public and private sectors have focused their attention on the enormous tasks of improving the scope of coverage for acute health care costs and the financing of pension plans. We are only just beginning to focus on the need to establish a systematic program of insuring and prefunding long term care costs in order to make them affordable to the majority of the population. Our current pay-as-you-go approach has resulted in nearly half of nursing home costs being paid for by Medicaid and the other half being financed out-of-pocket. This generates great insecurity for the elderly. It forces middle income people to impoverish themselves, "spending down" almost all of their resources to become Medicaid eligible, and in that way, join a health care program intended for the poor. And it also encourages people to divest themselves of assets in order to qualify for Medicaid benefits.

But this situation is changing and it is changing rapidly.

Developments in Long Term Care Insurance

There has been a small private market for long term care insurance in this country for some time. Widespread misunderstanding among the elderly about the extent of Medicare coverage, coupled with other, higher priority uses for their funds are two of the primary reasons why spending for private long term care coverage had little appeal.

Recently, that has changed dramatically, as evidenced by the number of companies developing long term care insurance products, the number of individuals covered and the variety of products being developed. A recently completed survey by the Department of Health and Human Services (DHHS) Task Force on Long-Term Health Care Policies, of which I am a member, found that about 70 insurance companies now offer long term care policies and that there are currently about 423,000 policies in force. Three years ago, only 16 companies were identified by DHHS as selling long term care policies.

Although long term care has most of the characteristics of an insurable event, much about the nature and extent of the risk will only become known as we gain experience. Accordingly, the initial insurance industry response was a conservative one. The first generation of products tended to focus on institutionalization, covering only nursing home care following hospital confinement. We are already in our second generation of products and these are considerably more flexible and creative. Insurers are now beginning to cover care at home. In some policies, the insurable event keys off the concept of functional disability, not nursing home confinement. In the third generation of products, we will see the progression to more comprehensive and liberal benefit provisions, as private sector insurers and the consuming public become more sophisticated. It is important that the regulatory environment allow and encourage this development.

Within the last six months employer-sponsored group long term care policies have been marketed for the first time. Four commercial carriers, Aetna, Metropolitan, Prudential and Travelers, now offer a variety of group coverages; several others have announced plans to begin marketing group products. And a privately insured long term care plan for federal employees is in the planning stages.

Aetna is among the companies developing both group and individual products. Our experience might help you see where the industry is moving generally. At Aetna, we began offering an individually underwritten policy in October of 1985. Approximately 22,500 policies have already been sold. We have more recently begun to market a new long term care product for Retirement Communities and to date have sold four of these contracts.

Last year we surveyed a number of our major employer clients on their interest in sponsoring long term care benefits for their employees and retirees on a group basis. There was a generally favorable response, although only a small number of customers were ready to move quickly. Most were concerned about the costs of their existing retiree health benefit plans. Nevertheless, some were still interested in offering an employee-pay-all plan. These employers saw a long term value in making a plan available. In just the past year, our marketing department has seen a very noticeable increase in interest in long term care as an employee and retiree benefit.

Our first group long term care contract was signed this Spring with the State of Alaska. The opportunity to enroll in this program, which is entirely paid for by the retiree, was opened at the end of March, 1987. We have already signed up nearly 30 percent of the approximately 7,500 eligible retirees. Including spouses, a total of 3,120 people are now covered.

Considering that there was no individual solicitation for this plan, we are very pleased with these early results. We expect to add other group contracts in the near future.

A number of other insurers have also developed innovative ways of financing long term care and we anticipate that as time goes on, the variety of products available will expand. For example, Metropolitan entered the long term care insurance market a year and a half ago with the issuance of a pilot group contract covering residents of a Continuing Care Retirement Community in Virginia. In addition, they have entered into a joint arrangement with an HMO, Group Health of Puget Sound, under which coverage for nursing home, community-based and home health care has recently become available to some 60,000 eligible individuals. Importantly, this plan introduces a managed or directed care component, now so familiar in the provision of acute care benefits, into the provision of long term care.

Prudential has a group arrangement with AARP under which a nursing home and home health care benefit has been marketed by mail to members of the Association. Approximately 8,000 individuals have purchased this coverage. Travelers is marketing an employer-sponsored long term care product available to active employees and retirees, and to their spouses, and to the parents of employees.

Development of the Long Term Care Insurance Market

Although the costs of long term care seem to be a "natural" focus for the insurance mechanism and progress is being made, the market has been slower to develop than we would wish. A major past inhibitor to long term care insurance purchase was that elderly people were concerned primarily with the adequacy of their retirement income and with coverage for the costs of acute medical care. We now have the first generation of elderly going into retirement with both Medicare and supplemental Medigap protection, private pension benefits plus, incidentally, the very substantial capital appreciation in their homes, most of which are fully paid for. There are, however, other factors which have inhibited full market development of long term care financing products. In varying degrees, these factors still operate today. The most important of which are:

- A low level of consumer awareness about the risks and costs of long term care, coupled with a widespread belief that Medicare and supplemental Medigap policies cover long term care costs.

- A lack of usable data regarding the use and costs of long term care services, particularly in an insured environment, which makes actuarially sound pricing of products very difficult.

- An uncertain regulatory and tax environment for long term care insurance.

Consumer Awareness

It is obviously difficult to sell a product or service to individuals who are either unaware that they need it or are convinced that their need will be met in some other way. Yet this is the situation we find with respect to long term care.

A recent survey of the elderly conducted by American Association of Retired Persons revealed that 79 percent of those who thought they might need nursing home care believed the Medicare program covered these expenses. Such misconceptions about government assistance in paying for long term care are echoed in popular, and erroneous, beliefs about the role that private Medigap insurance plays in providing this kind of protection.

The need for better consumer education is the responsibility of both the private and public sectors. It should begin early, so that while people are working they begin funding an insurance program to protect themselves against the catastrophic costs of chronic illness expense. Level premium insurance coverage for long term care expenses is highly affordable at ages under 65. With the combination of advance funding through level premiums and risk spreading through insurance, the cost should be within the means of the majority of the population.

The HIAA has undertaken a number of initiatives to address the consumer awareness problem. These include the establishment of a toll-free telephone service for the elderly to inquire about the availability of insurance coverage; production of a Consumers' Guide to Long Term Care, which has been endorsed by both the AARP and the Department of Health and Human Services; and sponsoring of educational seminars on this topic.

Lack of Data

It has been particularly difficult for insurers to design and price policies when essential information has been unavailable. The data generally available in the past has been fragmented and there has been very little of it. For example, there are almost no data on spend-down under Medicaid. In this early stage of the development of long term care plans, access to federal and state data, in a readily usable form, would be most helpful.

We already have progress in this direction. Several national data bases on long term care will become available to the private sector this year, and this should help product design. Moreover, encouraged by members of the insurance community, the Department of Health and Human Services sponsored a technical conference on May 21 and 22 to communicate the contents of these data bases and ways that they can best be used. This activity is a small example of the kind of cooperation between private and public sectors that is required to deal with the long term care problem.

Need for Regulatory Flexibility

Another challenge is the need for a regulatory environment which recognizes that a new market and its products are somewhat fragile and can be damaged by rough treatment. An ideal statutory framework within which to develop long term financing products would be flexible and would encourage the necessary risk taking by insurers.

In order to facilitate state legislation and regulation that is appropriate to these unique insurance products, in December of 1986, the National Association of Insurance Commissioners (NAIC) adopted model legislation, which has already been enacted in several states and is being actively considered in a number of others. The HIAA was an active participant in this process and supports the NAIC's Model Act. We believe the approach taken in the Model Act to be flexible enough to meet the range of demands in the marketplace and yet strong enough to provide adequate consumer protection.

Tax Environment

Long term care insurance is a new hybrid product which, while highly desirable from a social perspective, has an uncertain or unfavorable status under the federal tax code. We are encouraged by the recent decision of the Finance Committee to request that Treasury conduct a study of the treatment of long term care insurance under the tax code. In order to fully support the market and promote product innovation, it is necessary for the federal government to clarify the tax status of long term care insurance and to remove barriers to several logical and effective product designs. There are four general areas of tax policy which warrant exploration.

The first category involves clarifying the tax treatment of long term care insurance reserves held by insurers and the investment earnings credited to them. We believe the proper treatment is analogous to the treatment of similar reserves supporting traditional life insurance products. That is, increases in these reserves and the earnings on them should be deductible by insurers to the extent that the reserves are required to support benefits under the contracts.

Similarly, we believe that premiums paid and benefits received under long term care contracts should be treated in a manner similar to that of medical care benefits. Because long term care insurance does not neatly fit within existing definitions in the tax code, clarification of both these items is critical.

Another group of issues might be labeled impediment issues. These involve modifications of the tax code to remove obstacles to employer sponsorship and funding of long term care coverage as an employee benefit. For example, it would be very helpful to be able to offer long term care insurance through Section 125 cafeteria plans. However, some tax experts believe level premium long term care insurance plans are currently prohibited under Section 125.

In addition, restoring the incentives for employers to prefund retiree health benefits that were removed in the 1984 Deficit Reduction Act (DEFRA) would be essential if we are to have any significant employer participation in the funding of such benefits. DEFRA restricts the prefunding of medical benefits for retired employees by limiting the deductibility of employer contributions and by taxing the earnings on funds set aside for such benefits. These rules are so onerous that virtually no employers prefund existing retiree acute care benefits and would not prefund long term care benefits either.

Lastly, allowing employers to transfer surplus pension funds to finance retiree health benefits would remove another impediment to employer sponsorship of long term care plans and potentially provide an additional source of funding.

The third category of issues could be called facilitation issues. This includes law changes to allow a variety of existing asset accumulation vehicles to be modified to include long term care options. These would include pension plans and life insurance contracts. One particularly attractive approach would allow employees to make a tax-free transfer of a portion of their vested benefits in savings and retirement plans in order to purchase long term care insurance. Another approach utilizing accumulations in life insurance contracts is being considered for the federal employees long term care plan. The use of existing asset accumulation vehicles is both logical and appropriate to the purchase of long term care insurance, but their status is either unclear or prohibited under current law.

The final category might be termed subsidization issues -- those issues specifically intended to encourage individuals to purchase long term care insurance. These might include the provision of tax credits, such as the $100 credit for long term care premiums proposed in Secretary Bowen's Report on Catastrophic Illness Expenses. A variation on this idea would be to target tax credits at the oldest members of the population for whom the cost of insurance is highest.

Summary and Conclusion

The long term care issue is significant. However, it does not demand crisis intervention. Solutions to the problem of long term care must continue to come from both the public and the private sectors. There will always be those without adequate resources to buy insurance. For this group, existing federal and state safety net programs for providing long term care will continue to be necessary.

The private insurance market is rapidly deploying its resources to address this issue. It is important to recognize that long term care coverage is part of the natural evolution of a system of income security. We see every indication that private long term care insurance will evolve and in the coming years offer widespread protection to the majority of the elderly. We believe that government policy can provide appropriate encouragement to the private market through consumer education, data sharing, flexible regulation and a supportive tax environment.

The private sector is responding to this new market in thoughtful and creative ways. With your assistance, that activity will continue and expand.

STATEMENT OF MARY NELL LEHNHARD, VICE PRESIDENT, BLUE CROSS AND BLUE SHIELD ASSOCIATION, WASHINGTON, DC, ACCOMPANIED BY DAVID STRACHAN, DIRECTOR OF PRODUCT DEVELOPMENT

Ms. LEHNHARD. Thank you. Mr. Chairman and members of the committee, I am Mary Nell Lehnhard, Vice President of the Blue Cross and Blue Shield Association, and with me today is David Strachan, Director of Product Development for the Association. Blue Cross and Blue Shields plans have a longstanding commitment to the health care financing needs of the elderly, covering about eight million subscribers under Medicare supplemental policies.

Our plans are now committed to solving the long-term care financing problem for the elderly, and over the past four years, have initiated product development. In the very early stage of this work, we conducted a major survey to support these new products. Importantly, we found almost half of our respondents in our survey were unaware that their current insurance did not cover long-term care expenses.

Among retirees, about 54 percent thought that they were covered, generally by Medicare. Once people were told of their risks for long-term care expenses, about 55 percent of the total sample said they were somewhat or very likely to purchase an insurance policy. Another important finding of the study was that the respondents preferred home care benefits over nursing home benefits by a two-to-one margin. This suggests to us that there is a place in the marketplace for products which offer a comprehensive range of services, not just institutional care. At the present time, about 40 Blue Cross and Blue Shield plans are researching and developing long-term care products.

We are hopeful that by the year-end, eight to ten plans will offer products and have them on the market. Two innovative products are discussed in our testimony.

As you are well aware, there are many unique challenges to developing and marketing long-term care products. As Mr. Burton said, major among these is the perception that their expenses are already covered. We strongly support a role for the Federal Government in clarifying the nature and extent of their risks for significant expenditures due to long-term care illnesses. The confusion on this issue is clearly a major obstacle to the development of the market for private insurance.

Another significant challenge is the lack of widely available actuarial experience on which to base premiums. Though there is a growing body of data, it is difficult to generalize just exactly what would happen under this new type of program. This problem is compounded when it is necessary to estimate a premium 10, 20, or 30 years into the future.

To help address this problem, we believe that the Federal Government could increase its efforts to improve the availability of costs and utilization data on long-term care services. We certainly commend the initial efforts undertaken by HHS and recommend that funds be appropriated to support the collection, analysis, and dissemination of other types of costs and utilization data.

A final challenge that insurers face in developing these new products is that carriers face the risk of regulation that may adversely affect the products they develop and offer.

The Government can again encourage the development of innovative products by providing for continued regulatory flexibility at all levels. We also support the National Association of Insurance Commissioners' model law, but we remain concerned about further regulatory development such as premature regulation of loss ratios or minimum standards.

Finally, we recommend the establishment of incentives for the purchase and sale of these new products. Most importantly, we recommend that the Government clarify—again as Mr. Burton recommended—that long-term care products are entitled to the same tax treatment as life insurance products. This clarification would help significantly in addition to clearing up what is now an ambiguity, it would allow us to add the conditions to our long-term care reserves that we need to accumulate the necessary capital.

Thank you for this opportunity to testify, and we look forward to working with you.

Senator MITCHELL. Thank you all very much.

[The prepared written statement of Ms. Lehnhard follows:]

TESTIMONY

OF THE

BLUE CROSS AND BLUE SHIELD ASSOCIATION

ON

LONG TERM CARE

before the

COMMITTEE ON FINANCE

UNITED STATES SENATE

by

MARY NELL LEHNHARD
VICE PRESIDENT

June 12, 1987

Mr. Chairman, and Members of the Committee, I am Mary Nell Lehnhard, Vice President of the Blue Cross and Blue Shield Association. With me today is David Strachan, Director, Product Development. The Association is the coordinating organization for the 77 Blue Cross and Blue Shield Plans across the country. We are pleased to have the opportunity to address the Committee on this important topic -- the financing of long term care for the nation's elderly.

I would like to begin my testimony by briefly citing some of the compelling statistics related to long term care, and its current and future cost to society. Then I would like to share with you some results of the Blue Cross and Blue Shield Long Term Care Product Development Project and report on our progress in developing long term care financing products. Finally, I would like to propose for your consideration some ways the federal government might help individuals and the private sector finance the potentially catastrophic cost of long term care.

The Committee is no doubt already aware of the demographic and financial scope of the long term care financing problem. Individuals over age 65, approximately 30 million people comprising over 13 percent of the population, are at high risk for needing long term care services. This portion of the population will grow steadily to over 55 million people by the year 2030. They will comprise over 18 percent of the total population. The number of individuals over the age of 85 will grow especially fast, three to four times faster than the general population. Thus, we can expect a steadily increasing need for long term care services among the nation's elderly.

According to preliminary CBO estimates, the nation's cost for long term care in 1985 was approximately $44.9 billion. By far the most significant portion of this total went to pay for services for the elderly. Currently approximately half of all long term care expenses fall directly on the shoulders of the elderly and their families. Most of the rest of the expense is borne by state Medicaid programs. Many elderly first become eligible for Medicaid when they have been impoverished by long term care expenses. Private insurance programs and the federal Medicare program, the two mechanisms which pay for most of the nation's health care, play a small role in the financing of long term care services. They each cover only one to two percent of long term care expenses.

As administrators of the Medicare program, Blue Cross and Blue Shield Plans have a significant and long-standing commitment to the health care financing needs of the elderly. Also, as private carriers Blue Cross and Blue Shield Plans cover almost eight million subscribers in Medicare supplemental insurance policies. We want to make it possible for the average person -- hard working and self sufficient -- to enjoy his or her retirement with the confidence that their health care needs -- both chronic and acute care -- are adequately covered. The elderly should have the confidence that their savings will be available to pay for other necessities -- food, clothing and shelter -- and will not be wiped out by long term care expenses.

The Blue Cross and Blue Shield organization is committed to helping solve the long term care financing problem. However, the development of the private long term care market has been slow thus far, and it still faces many serious obstacles. It should be recognized that the private market will never be able to address the needs of all segments of the population. Those individuals already over age 85 or already afflicted by chronic illness will probably not be covered by private insurance, nor is it likely that the lower income elderly will be able to afford to purchase insurance.

The Blue Cross and Blue Shield organization believes that the complexity and magnitude of this problem precludes any single approach as a complete solution. We support those approaches which rely first on flexible, innovative private sector solutions while retaining public programs to protect those without resources to participate in private programs. We oppose unnecessary regulation of the private long term care market because we believe that to restrict this emerging market would hinder development of innovative products.

Blue Cross and Blue Shield Long Term Care Product Research

Over the past four years, the Blue Cross and Blue Shield Association and Plans have initiated development of long term care financing products. As part of that effort, a joint Association/Plan study was conducted into the design and feasibility of long term care products.

The market research phase of this study included eight focus groups and a phone survey of over 2,800 households. I believe some of the findings will be of interest to the Committee.

First, we found that almost half of all respondents were unaware that their current insurance did not cover long term care services. Almost half of all respondents thought they were already covered and did not need additional insurance for long term care. Among retirees, 54 percent thought they were covered, generally by Medicare.

In spite of a general lack of awareness about long term care, our study found a surprisingly strong market interest in long term care financing products. Once people were told of their risk for long term care expenses, approximately 55 percent of the total sample said they were somewhat, or very likely to purchase a long term care policy within the next two years if one were made available to them.

A third important finding of the study was that respondents preferred home care benefits over nursing home benefits by a two to one margin. This suggests to us that coverage for institutional care is not the public's only consideration, and that there is a place in the market for products which offer comprehensive coverage for a range for services, not just institutional services.

Finally, our study found that financial security and maintaining independence were the two most important reasons for purchasing long term care coverage. The elderly want this security not to preserve assets for future generations, but simply to ensure they can have access to necessary care without impoverishing their spouse or being forced on to Medicaid.

The results of this research project have been shared with all Blue Cross and Blue Shield Plans to assist their efforts in developing long term care financing products. In addition, the Blue Cross and Blue Shield Association has used this information in support of the Department of Health and Human Services Task Force on Long Term Health Care Policies and has shared it publicly at conferences on long term care financing products.

Blue Cross and Blue Shield Long Term Care Product Development

At the present time, approximately 40 Blue Cross and Blue Shield Plans are researching and developing long term care financing products. We are hopeful, as these efforts continue, that 8 to 10 Plans will offer products by year end. I would like to spend a few minutes discussing two Blue Cross and Blue Shield Plan products, one currently on the market and one which will be introduced soon.

In late 1986, Blue Cross of Washington and Alaska began offering "Lasting Care", long term care coverage sold in the state of Washington. Lasting Care covers nursing home and home health care services after a medically necessary hospital stay or after the individual has been disabled for 180 days. Lasting Care offers a "service benefit" contract which means the program will pay up to 100 percent (or 80% based on the option selected) of the usual charges if the individual enters a participating nursing home or needs the services of a contracting home health care agency. This type of benefit, as opposed to a fixed dollar amount per day, for instance, provides the best coverage because most out-of-pocket costs are eliminated. In addition, access to home health care services is not dependent on a nursing home stay, as is the case with many other policies. Rather, individuals are eligible for home health care services after a short hospital stay and after concurrence between qualified physicians and the Plan's case manager.

The second product I would like to mention is "Home Care Plus" which will be offered on a pilot basis by Blue Cross and Blue

Shield of Arizona this summer. This product provides home health care benefits for elderly with chronic disabilities. It also includes a managed care component to assess the need for services and to monitor their delivery. It is intended to help the elderly maintain their independence and live in their own homes as long as possible. If this innovative benefit proves successful, it may be expanded to be offered on a state-wide basis.

The Challenge of Long Term Care Financing Products

While the Blue Cross and Blue Shield Association and Plans are committed to developing long term care financing products, there are many unique challenges inherent in these products.

First, as mentioned earlier, in spite of the growing press and media attention to the problem of long term care, the general perception among the public is that they are already covered for long term care expenses. As long as this perception continues, the public will see little need to purchase private long term care insurance.

Another significant challenge is the lack of widely available actuarial experience on which to base premiums. Though there is a growing body of data related to current utilization of nursing home and home health services, it is difficult to generalize from this data as to what would happen under an insurance program. This problem is compounded when it becomes necessary to estimate cost and utilization experience 10, 20, or 30 years into the future. These and other problems recently forced one of the major long term care insurers to cease offering the coverage and the business was sold to another company.

In addition, long term care insurance also is fundamentally different than the types of health insurance currently on the market. For example:

- Long term care insurance covers chronic illnesses, where onset is more difficult to define and for which a cure or recovery is much less likely.

- Long term care insurance is rated on a level premium basis. That is, the premium is a fixed amount each year and the coverage is designed to be purchased years before there is a high likelihood of need for the services. It is over-rated in the early years and under-rated for the very old.

- Finally, most long term care services are currently provided on a voluntary basis by the families and friends of the elderly. There is certainly a risk that the availability of insurance may replace these voluntary services with insurance-financed care.

A final major challenge insurers face in developing and offering long term care policies is related to the potential for state and federal legislative or regulatory actions regarding long term care products. Carriers, particularly Blue Cross and Blue Shield Plans, face the risk that new regulations may adversely affect the products that they develop and offer. Of particular concern to Plans is that regulators may fail to grant necessary premium increases or may choose to withhold premium increases on other products because of a Plan's larger reserves that are necessary for the future solvency of its long term care product.

For all of these reasons, we anticipate that the growth in long term care products offered by Blue Cross and Blue Shield Plans will be steady, but slow over the next several years. Further, it will be important that we move deliberately in order to learn to effectively design and manage these products for the best interests of our subscribers.

Potential Federal Government Initiatives

The Blue Cross and Blue Shield Association commends both the Administration and the Congress for the thorough and serious study they are giving the problem of financing long term care services. The Association participated in the Private Sector Advisory Committee to the Bowen Commission on Catastrophic Health Care Expenses which addressed long term care. The

Association has also actively supported the Department of Health and Human Services Task Force on Long Term Health Care Policies. The Association commends the general approach that has been taken by these efforts to date -- that the federal government should encourage and support private sector solutions to the long term care financing problem.

We believe there are a number of ways in which the federal government could help the private sector to develop and offer long term care policies. First, we strongly support a government role in clarifying for the public, the nature and extent of their risk for significant long term care expenses under public programs. The public confusion on this issue is clearly a major obstacle to the development of the market for private insurance.

Second, the federal government should increase its efforts to improve the availability of cost and utilization data on long term care services. We commend the initial efforts undertaken by HHS in the organization of a long term care data conference this May, but we would recommend further that funds be appropriated to support the collection, analysis and dissemination of other cost and utilization data for long term care services.

Third, we recommend the establishment of incentives for the purchase and sale of long term care insurance. We believe that the government should be willing to offer insurers incentives to enter this high risk market. Most importantly, we recommend that the government clarify that long term care products are entitled to the same tax-favored treatment as life insurance products and that this favorable treatment be available to all types of insurance companies who choose to sell long term care products. In addition to various technical advantages, this clarification would allow additions to long term care reserves to accumulate on a tax-free basis -- a move that was recommended by the Bowen Commission and others -- and one we strongly support.

An additional incentive along the same lines involves the computation of reserves, ultimately for the purposes of determining the tax liability of the insurer. Under current law, insurers are allowed to claim a deduction based on their reserve levels. Basically, higher reserve levels work to lower the insurer's tax liability. To compute the reserve level for long term care products, insurers must now follow what is known as the "two-year preliminary term" method. Simply put, this means that the insurer cannot reduce tax liability based on additions to reserves until the policy has been in force for two years. This two-year term could be eliminated or shortened to a one-year period for long term care products which would allow insurers to increase reserves earlier in the life of the product and in turn lower the insurer's tax liability. We believe this change would offer insurers a modest incentive to sell long term care products, and because there are relatively few products in the market, there would be little revenue impact to the government. We continue to look for additional tax incentives of this nature that could encourage the market and would be pleased to share them with the Committee.

Fourth, we recommend continued regulatory flexibility at all levels of government to support the development of a variety of private sector long term care financing products. The Blue Cross and Blue Shield Association and its member Plans have actively participated in the development of National Association of Insurance Commissioners (NAIC) model legislation and regulation. We support this initiative. However, we remain concerned that further steps such as the premature establishment of additional minimum standards, loss ratios or other regulation will inhibit the development of innovative private sector solutions.

We want to thank the Committee for this opportunity and we would be pleased to work with you as you continue to search for ways to finance long term care services.

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Senator MITCHELL. I will begin this round of questioning by asking Ms. Lehnhard and Mr. Burton a question. In your testimony, you didn't discuss the possibility of a Medicare long-term care benefit. Does that mean that you think private insurance plus Medicaid will be adequate to deal with this problem in the future?

Mr. BURTON. Senator, would you like me to start?

Senator MITCHELL. Either one. Sure, go ahead, Mr. Burton.

Mr. BURTON. I guess I do. I think the private insurance business feels that we ought to be given a chance to see if we can't deal with this problem. And if one looks back not too many years, one would have made the same prediction then, that the private insurance business really couldn't provide adequate Medigap coverage for the elderly. Yet today, 70 percent of then have it.

I am very optimistic that, once we can encourage employers or get employers to sponsor these products, we would have a good shot at significantly penetrating the elderly.

Senator MITCHELL. What, if anything, has prevented you from doing that for the past two decades?

Mr. BURTON. All of the reasons mentioned in the testimony, the lack of demand being a principal one; and in the decades that have preceded, there was a very distinct problem of affordability, which is diminishing rapidly now. The elderly are becoming among the most affluent group in the country.

Senator MITCHELL. Thank you, Mr. Burton. Ms. Lehnhard.

Ms. LEHNHARD. My response is very similar. There is a very large proportion of the Medicare-eligible population that we feel we could develop an affordable product for. However, I would be quick to mention that there are three groups that we don't think we will be able to take care of: the low income, those who already have a need for institutional care, and the "old-old."

And one of the areas we are focusing on is what Medicare might do for the "old-old," people over 85 now, where the private market will probably not be able to step in because of the very high risk.

Senator MITCHELL. If we were to disregard your advice and adopt a program that was structured with a significant exclusionary period, deductible in point of time in effect as has previously been discussed, and a substantial copayment requirement, in your judgment would that help or hinder development of private long-term insurance?

Mr. BURTON. I realize that many believe it would be attractive to insurers, but I would have to say I believe it would not be, given the most recent history of the Medigap program where now the Medicare Program will be expanded and wipe out a significant market for private insurers. I think most insurers and employers, too, would take a wait-and-see attitude, would hold back, would not make the investments of millions of dollars to develop long-term care insurance, if they saw a significant Government action where there was a stop-loss feature, let's say, after two years.

Now, obviously, if it were five years, my comments would not be quite as——

Senator MITCHELL. The problem with the employer-based option, Mr. Burton, is that of course trends in that area are in the opposite direction. We have an alarming increase in the number of persons in this country who are employed and without health insurance.

And were we to rely on that for a resolution of the problem, it seems to me we would be in effect jumping on board an already leaking ship. Doesn't that concern you? There are now 24 million Americans who work and who don't have health insurance, and the number is rising at a rapid rate. Does that not give you pause to suggest that we rely on employer-based programs to provide an even additional benefit when employers are bailing out of programs with lesser benefits?

Mr. **Burton**. I realize that there has been some deterioration in the number of people who are uninsured; but in the larger context—the total number of people who are—it is a relatively small change. And what we are dealing with here is a brand-new coverage, and we have a tremendous group of people to reach through normal means; and we think we can enlist employers in doing that—not necessarily at their cost, but through sponsorship and provision of opportunities to their employees to purchase these products.

Senator **Mitchell**. Mr. Atkins, you ought to give your input. Do you agree with Mr. Burton and Ms. Lehnhard that private insurance and Medicaid can deal with this problem adequately in the future?

Mr. **Atkins**. Certainly not the way things have been working, as you pointed out, Mr. Chairman, over the past two decades. And I share with you the concern of the increasing number of Americans who are not covered by health insurance through their employers. And as I pointed out in my testimony, we find that is perhaps the major obstacle to getting people off the welfare rolls.

But I do think that, by working together, we ought to be able to construct something with the private sector. I do think Government has a role to play, but we haven't done it yet. I think you are quite correct.

Senator **Mitchell**. Thank you, Mr. Atkins. Thank you, Mr. Burton and Ms. Lehnhard. Senator Durenberger.

Senator **Durenberger**. Mr. Chairman, thank you. Mr. Atkins, let me pick up on where the chairman left off. Again, I don't want to bore you with my relatives, but you said looking back on the last two decades, you wouldn't have confidence in going back to private insurance systems; but in the latter part of the 1950s, I dealt as a grandchild with my paternal grandmother going into a nursing home. And her four children all chipped in, and they did it. We all helped in one way or another by visiting and doing all of the things that a family does to provide for those last years of an elderly grandparent. My maternal grandfather died in 1967, and by 1968 or 1969, my maternal grandmother, who wasn't able to live alone—she had one child, my mother. So, she went into a nursing home, and the first thing that we discovered was that we were about the only people there who were prepared to use her savings and those of her spouse to provide for her care.

Now, that came as sort of a shock to us that, in this 10-year interim—at least in my life—something else had come along, i.e. Medicaid and medical assistance and a variety of other things. Now, it seems to me that in the last 20 years we have all come to the notion that there is a safety net there for everybody. And so, in our planning for our families' retirement, we somehow are planning on that safety net to be there; and that reflects on our savings. It reflects on our insurance; it reflects on our choice of benefits that we might make. So, one of the first things, it seems to me, we all need to do is start changing the way we think about responsibility at various levels.

Would you say, Mr. Atkins, that it is impossible now? I mean, it seems to me the States are so involved in running the nursing homes in this country through the Medicaid Program; is there a clear way to unhook State government and Medicaid and the welfare system from nursing homes so that there would be a market for other kinds of service delivery that is responsive to other kinds of financing, other than the Medicaid financing?

Mr. **Atkins**. I think there are a number of ways of doing that, Senator. As I mentioned, Medicare Part C is something that certainly the Congress needs to think about. It doesn't quite satisfy your point of how do you make the match with the private sector; there may be another vehicle.

I think you hit the problem right on the head in terms of your own description of what went on there. My problem with the current system of using Medicaid to fund nursing home care is that most people don't know what you have described—I have found—and I think this committee had discussed before the mistaken impression among the elderly that, in fact, it is Medicare that is going to cover long-term care; and then they find out, no, it is not that but it is Medicaid.

I guess I wouldn't mind it as much if we had a policy in this country of announcing very clearly that it is Medicaid, this program that the Congress set up back in 1966 for the poor, that has now become responsible for spending over half of its budget for long-term care for the elderly, many of whom certainly don't view themselves as poor, but at $25,000 a year when they go into a nursing home, soon become poor.

My problem is, one, that it is not fair, that what we find is that if you have a good tax lawyer or estate planner, then you kind of find out that Medicaid is going to come along and help you, and you do something about it to plan for it. And for the people who don't know it, well, they end up being impoverished. And two, that it ends up that long-term care, as I tried to point out, is competing with the limited amount of monies the States have for poor women and children.

So, we would like to see the competition stopped between our fighting over the dollars over whether we are going to feed poor women and children or whether we are going to care for the elderly because we think, as a nation, we want to do both. And we ought to be very up front about it.

And we ought to have a policy that says that we are going to provide for elderly in nursing homes, if that is what they need, or more efficient choices which are currently not available; and we also want to help poor women and children at the same time.

Senator **Durenberger**. Ms. Lehnhard, can I go back to something you said about needing to clarify the distinction between long-term care insurance and life insurance, and just ask you to amplify on that a little bit?

Ms. LEHNHARD. If it were clarified that these long-term care insurance products were treated as life insurance products, we would be able to add to our reserves on a tax-free basis, build them up faster and not charge as much for premiums.

Right now, here is quite a bit of ambiguity about how they are to be treated we think it should also be clarified that you don't just have to be a life insurance company to offer these. Anybody offering that product could receive that treatment on that particular product.

Senator MITCHELL. Senator Chafee.

Senator CHAFEE. Thank you, Mr. Chairman. Mr. Atkins, I listened with enthusiasm to your discussion about dissolving the link between AFDC and Medicaid. It seems to me that is one of the things we have really got to do if we are going to help, principally in connection with the welfare programs and end the problems that you have cited.

I wasn't quite sure what you meant when you said on page 9 that Medicaid serves the poor and the nonpoor alike. Briefly, how did you get to that conclusion?

Mr. ATKINS. What I meant by that was Medicaid serves the poor in terms of its being obviously the health care program we provide for poor women and children on AFDC; but Medicaid also pays for—as we have been discussing—long-term care costs for people who may not have been poor before they went into a nursing home. And they either impoverished themselves or——

Senator CHAFEE. They impoverished themselves to get on the Medicaid?

Mr. ATKINS. Or again, hired a good estate planner or a tax lawyer and were able to know enough about what to do to get on the Medicaid.

Senator CHAFEE. I noticed that you discussed that transfer of assets, and that is a problem you really run into to a considerable degree?

Mr. ATKINS. Yes, and to a very inequitable degree. As I pointed out to Senator Durenberger, it turns out that not all the elderly know in fact they are entitled to this program if they do the right things. And I think there is something wrong with that.

Senator CHAFEE. You mentioned case management. Some of the prior witnesses discussed case management and said we just plain don't have the personnel—the trained personnel—to do that. Have you had some success?

Mr. ATKINS. I thought about that when one of the previous witnesses mentioned that; and unfortunately, I think he is correct. What we are doing as the welfare commissioners across the country is we are putting case management into our new welfare system to manage AFDC cases, young women with children.

We are just beginning to think about how to do that for the elderly as well; and I would agree that we don't have the personnel yet. I will give you the statistics in Massachusetts, which are obviously what I know best. We have a caseworker for every 120 or 130 AFDC cases, and that is probably on the low end of the range of caseworker to client ratio. When it comes to Medicaid, we have a caseworker for every 400 Medicaid cases in our long-term care units. We have got to do a better job of having more personnel if we are going to provide case management.

Senator CHAFEE. What do you think of a proposal that I have suggested for mid-America in which an individual could buy insurance under Medicaid, with a premium based on an income adjusted premium? So, somebody could just buy that insurance. Do you think many would go for it?

Mr. ATKINS. I don't think initially because I think one of the problems you would run into is that people are unwilling to admit that they are going to need this product. I think it is, as you have heard testimony before, perhaps analogous to what we want to do or where we have come with life insurance and certainly health insurance where we have a problem selling the public on the need to do it. But we have got to start at some point in time, a[illegible] am very much in favor of a proposal like that. It will be a hard sell, but there have been other things in our society that have been a hard sell as well; and I think it is terribly important we begin to embark down that road.

Senator CHAFEE. I think one of the best parts of your testimony is to indicate this problem of possible competition between poor women and children, on one hand, and providing proper services for the elderly, on the other hand. We just don't want those to come into conflict, which is very liable to happen under the present existing Medicaid system.

Let me ask you about something on page 8. You talk about the greater flexibility to design programs to enhance community-based services as an alternative to institutional long-term care. I believe in that very strongly. Do you see much concern that, if we embark on that, that we will see a whole host of possible clients emerge that currently aren't there, if we are going to, for instance, assist in the care for the elderly that some children are now taking care of in their own homes?

Mr. ATKINS. Absolutely. I don't think we should walk into that with our eyes closed. There is a huge unmet need out there; and as this committee well knows, that need is going to grow. The number of elderly in this country is supposed to double by the year 2010, and I don't think we as a society have adequately got the programs in place for what they are going to need. Certainly, as this committee has heard testimony before, it is not only institutional care. That is not appropriate; it is not cost effective. There are other programs, such as home-based care, community-based care, nursing homes without walls, retirement care communities that are out there, that we have got to put together in some kind of comprehensive way; but we shouldn't kid ourselves about the demand that is out there now and what it is going to become.

It is very large, and it is growing; and it is going to take some money.

Senator CHAFEE. Let me ask the insurance folks just one quick question. It seems to me if you designed a policy for long-term care that it would be most attractive—in trying to make it financially feasible—if there were a very significant deductible up front and then broad coverage after that. It would seem to me people would be prepared to pay a significant sum, knowing that thereafter they were covered. Is that true from your experience or not, rather than a copayment as you go along?

Mr. **Burton**. I guess generally our experience is that people like fairly rich benefits; but as an insurance industry, we try to respond to the market and we make available plans with fairly high deductibles. But I wouldn't expect that they would be the most popular sellers.

Senator **Chafee**. Thank you. And thank you, Mr. Chairman.

Senator **Mitchell**. Thank you, Senator. Mr. Burton, we are talking here about a mixed private/public plan in which public program benefits would begin after a stated period of time. And that defines precisely the risk for the insurer and for the individual citizen who will both be a beneficiary of the Government program and insured if he or she were to purchase a policy for that stated period. That is, let's hypothetically say two years for a program that said that public program benefits would begin to be paid two years from the date of eligibility. It seems to me there would be an enormous incentive; and many insurance company officials, other than yourself, have told us they think that is a good idea because it then creates a specific market. So you then have a policy for two years that you can sell. So, in terms of your response regarding the relative level of benefits, certainly in insurance—as in every other area of human activity—people want to get the most benefit for the least cost.

But here we are talking not so much about the level of benefit within the stated period—although that would obviously be a factor—but we are talking about the mere fact that we are defining a precise period within which you could then market the policies. You may feel free to comment on that if you wish.

Mr. **Burton**. Fine. If that were to happen, there would be insurance products filling that first two-year period. I think I would return to the point that I made before though that I think employers would be even more reluctant to make those products available to their employees because they would anticipate that the Congress would lower that two-year figure to one year or take on the problem totally. So, why start a commitment from myself to my employees? There would be an increased reluctance; it would have an inhibiting effect, I think, on both employers and insurers for the purchase of any form of coverage.

Senator **Mitchell**. Thanks to all three of you, very much. Your testimony has been very useful, and we look forward to working with you on this difficult but important problem.

The hearing is concluded.

[Whereupon, at 11:55 a.m., the hearing was concluded.]

[By direction of the chairman the following communication was made a part of the hearing record:]

NATIONAL COMMITTEE TO PRESERVE
SOCIAL SECURITY AND MEDICARE

1300 19th Street, N.W., Suite 501, Washington, D.C. 20036 (202) 822-9459

STATEMENT OF

FORMER CONGRESSMAN JAMES ROOSEVELT

CHAIRMAN OF THE NATIONAL COMMITTEE

TO PRESERVE SOCIAL SECURITY AND MEDICARE

SUBMITTED TO

COMMITTEE ON FINANCE

SUBCOMMITTEE ON HEALTH

U.S. SENATE

REGARDING

FINANCING OF LONG-TERM HEALTH CARE

JUNE 12, 1987

I am James Roosevelt, Chairman of the National Committee to Preserve Social Security and Medicare. In that capacity, I represent more than four million members, for most of whom Medicare is the primary health insurance protection, but who have little or no insurance protection for long-term care.

Unfortunately, the catastrophic health insurance legislation now being considered by Congress offers no additional insurance protection against catastrophic long-term care costs, for many the most catastrophic expense of all. Mr. Chairman, this hearing to examine the financing of long-term health care is critical. Financing is apparently the major stumbling block to including long-term care in catastrophic health insurance legislation. I hope your work in this area will resolve the problem and enable Congress to provide this vitally needed protection.

We are perfectly aware that providing comprehensive catastrophic health insurance to seniors represents an important financial commitment. But I believe where there is a will, there is a way. I don't think that Congress lacks the will. It just has to find the way.

In an era of large government deficits, most policymakers worry that the American people would not support a new, costly government commitment. But this argument ignores the fact that American families already pay for catastrophic illness through out-of-pocket costs, insurance premiums and tax dollars that finance Medicaid. I believe today's workers would be willing to help finance catastrophic health insurance if they understood that it would help to provide immediate financial protection for parents and grandparents while at the same time building up protection for themselves when they retire.

A National Committee member from Cicero, Illinois, recently described the devastating impact that a long-term care illness can have on the whole family even when the family does not exhaust all its savings.

> (Pop) had to be put in a nursing home - at a cost to my mother of about $2,400 per month. And neither Medicare nor Medicaid could help because my parents had a nest egg. The law is without pity.... Had my father lived for just two more years in the nursing home, my mother would have had to spend the rest of her life in poverty. But God called Pop to his eternal rest in one year, rather than two. My mother and I can never forget the terrible feeling of relief we had when Pop died. We can only live with it in shame. We loved him.

Some would impose the total burden of financing long-term care on seniors, but this is unrealistic. After retirement, most individuals no longer have the resources to be able to finance all their health care.

In a recent survey, our members overwhelmingly rejected the idea that seniors should bear the full cost of any new Medicare coverage. And more than 70 percent said that it would be a significant financial burden if they had to pay more than $1,000 each year in premiums and out-of-pocket medical expenses.

The National Committee proposes to pay for catastrophic health insurance legislation, which would include coverage for long-term care, by (1) increasing contributions paid by senior citizens, (2) increasing contributions paid by the working population and (3) controlling costs through effective care management. Without adequate financing, comprehensive catastrophic health insurance will never become a reality. To do nothing is to condemn millions of seniors and their families to poverty and reliance on welfare.

Contributions from Seniors

The National Committee has proposed in previous testimony to this Committee that seniors pay for no more than half of the cost of a comprehensive Medicare catastrophic health insurance package through premiums, deductibles and copayments. In regard to premiums, it is important that everyone contribute a fair share, but no more than they can reasonably afford. While deductibles and copayments for long-term care would still be significant, private insurance plans possibly could cover these out-of-pocket costs. Private insurers would be much more likely to insure specific deductibles and copayments than they are currently likely to insure open-ended, non-Medicare covered, long-term care expenses.

Contributions from the Working Population

One of the basic principles of social insurance is that the working population finances benefits for the dependent population. Increases in payroll taxes and/or income taxes will be necessary. Eliminating the wage base for Medicare payroll taxes, for example, would raise about $6 billion a year. This would also improve equity by requiring the six percent of the population earning above the wage base to pay the same percent of earnings as other workers. To the extent that seniors worked or had taxable income, they would also contribute through higher payroll taxes or income taxes.

Contributions from Cost Savings

Medicaid currently pays for about half of long-term care. Medicaid would save most of this after the implementation of catastrophic health insurance legislation which included coverage for long-term care. Therefore, this savings should be transferred to Medicare.

Our current system for paying long-term care costs is very fragmented and, as a consequence, inefficient. By establishing a comprehensive, national program, with effective care management, Medicare will be able to coordinate a more efficient use of these available resources.

After a lifetime of work and saving, millions of Americans face the tragedy of bankruptcy and poverty because Medicare coverage is inadequate, as Mary Bellamy of Knoxville, Tennessee, recently described to me:

> All of our life savings are gone now. Henry and I together got $831 Social Security. They (the nursing home) will take $562 of his and that will leave me $269 to live on, which sure will be rough going, me with this sickness I have. My medicine really costs ($80 a month). I'm going to try to get SSI, Medicaid and food stamps.

Let this be the Congress which has the courage to provide affordable and adequate Medicare coverage for long-term care. Catastrophic health insurance legislation is the perfect opportunity.

WJL:SUB-HEALTH